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Contact Hours: **4**

Ethics for Case Managers
CCMC Board-Certified Case Manager CE

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

- Summarize the fundamental ethical principles generally associated with the practice of healthcare as a whole.
- 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, organ donation, and suicide risk.

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, 2023). 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 refers to a system or set of moral principles that govern behavior, including job performance. Ethics includes beliefs about the "rightness" and "wrongness" of actions as well as the "goodness" and "badness" of motives and outcomes (Merriam-Webster, 2024a). Case managers must practice according to the ethical principles of their profession.

The field of medical ethics evolved rapidly after it came to light that humans had been experimented on without consent in a tortuous manner within concentration camps during World War II. Currently, the scope of medical ethics is broadly comprised of research ethics, public health ethics, organizational ethics, and clinical ethics (Varkey, 2021).

Due to the complex array of case management services provided to clients, case managers shoulder an enormous amount of ethical responsibility during the performance of daily tasks. Failure to comply with the ethical standards of the profession can lead to client harm. For this reason, being knowledgeable about ethical standards is important in order to prevent intentional or unintentional harm to the client (CCMC, 2024).

WHAT ETHICS IS NOT

Understanding what ethics is **not** can be useful to improve understanding about what ethics is. Being able to distinguish in this way could potentially prevent avoidable harmful situations from occurring during patient care.

Ethics is not:

- Law
- Codes of ethics (which are simply tools to help guide ethical behavior)
- Codes of conduct
- Hospital etiquette
- Hospital policy
- Public opinion
- Ideology
- Following orders of a manager or supervisor

(Johnstone, 2023)

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 (comparative) 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* (Johnstone, 2023).
- **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 (Britannica, 2023). *Example: not restraining a client against their will even if it may help the client in some way.*

Ethical Principles and Healthcare

There are four 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. (The Greek word *autos* means "self," and *nomos* means "rule.")
- **Beneficence** means working actively for the best interests of the client. This principle highlights the general concept of doing good for others. (The Latin word *bene* means "good," and *facere* means "to do.")
- **Nonmaleficence** means to do no harm to a client. (The Latin word *malum* means "evil," and *facere* means "to do.")
- **Justice** refers to treating all individuals with fairness, equality, and appropriate treatment. (The Old Latin word *justus* means "law, right.")

These four ethical principles are general standards of conduct by which actions can be measured (Varkey, 2021; Johnstone, 2023).

AUTONOMY

The foundation of the ethical principle of autonomy is that all human beings have inherent and unconditional value that gives them the ability to make their own decisions and moral choices. Over 100 years ago, in 1914, Justice Cardozo affirmed the ethical principle of autonomy in a court decision, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body" (Johnstone, 2023).

The following acts **violate** the patient's right to autonomy:

- Treating a patient without their consent
- Treating a patient without providing them with all the pertinent information they need to make an informed and intelligent decision
- Withholding information from a patient even though they have stated they would like to receive the information
- Delivering information to a patient even though they have stated they do not want to receive the information
  (Johnstone, 2023)

Autonomy is not absolute and is invalidated when an individual acts to cause harm to themselves or another person or persons, such as by suicidal or homicidal intent. The principle of autonomy also does not pertain to individuals who are not of sound mind or who are not competent to make their own rational decisions. This includes children and some individuals with developmental, mental, or physical disorders. Governmental and institutional policies and procedures exist to assist clinicians to thoroughly assess incompetence in individual patients.

The principles of informed consent, veracity, and confidentiality are derived from the ethical principle of autonomy, as they form the basis for enabling patients to be autonomous (Varkey, 2021).

Informed Consent

One of the main legal and ethical issues and a cornerstone of the ethical principle of autonomy is that of informed consent. Informed consent is a routine and fundamental part of provider–patient interactions and includes the process of educating a patient about risks, benefits, and alternatives of a given intervention. To support a patient's right to autonomy, the patient must be competent to make a voluntary decision about whether to undergo the intervention.

Factors of concern in obtaining informed consent may include:

Hearing and visual impairments

Impaired communication (written and verbal)

Values and beliefs

Fluctuating or diminished decision-making capacity

Implicit in providing informed consent is assessing the patient's understanding, rendering an actual recommendation, and documenting the process. The following are the required elements for **documentation** of the informed consent discussion:

- Nature of the intervention
- Risks and benefit of the intervention
- Reasonable alternatives
- Risks and benefits of alternatives
- Assessment of the patient's understanding of the elements listed above

Exceptions to the requirement include:

- Patient incapacitation
- Life-threatening emergencies with inadequate time to obtain consent
- Voluntary waived consent
  (Shah et al., 2023)

It is the ethical responsibility of the case manager to respect the client's right to self-determine a course of action and to support the client's independent decision-making. The case manager can do so by providing 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.

Veracity

Veracity, which means telling the truth, is an integral part of establishing rapport and maintaining trust throughout the client and case manager professional relationship. A hallmark of veracity is that a client's autonomy gives them the right to choose to receive full disclosure about their medical condition or to refuse full disclosure. A simple example of this concept is a pregnant patient who decides not to learn the sex of their unborn baby during an ultrasound.

In the United States, full disclosure of diseases and prognoses to patients who wish to know is considered the ethical standard. However, this is not always the norm in non-Western societies, where the diagnosis is often disclosed to the family and not to the patient in order to minimize the anxiety and uncertainty that full disclosure might bring to the patient (Varkey, 2021). The case manager should keep this in mind when interacting with clients and family members from different cultures who may not be aware of or understand the ethical norms in the United States.

Confidentiality

The third core concept of autonomy is confidentiality. Privacy standards set forth in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 legally obligate the case manager

and other healthcare professionals to safeguard a client's health information. The advent of electronic medical records and the rise in popularity of social media pose new concerns for how to adequately protect the confidentiality of patients. Case managers must be vigilant to safeguard client's medical information and thereby respect the patient's autonomy (Varkey, 2021).

CASE

Dolores is a nurse case manager for a busy hospital unit. She receives a new case assignment for a 73-year-old widow named Samira Ahmadi, who arrived to the hospital escorted by her son the night before. Mrs. Ahmadi's symptoms include nausea, unexpected weight loss in the past few months, dark urine, and jaundice. Although English is not her first language, Mrs. Ahmadi is able to speak basic English. She is alert and oriented and deemed to be of sound mind.

Mrs. Ahmadi's son, who has not been legally designated as the healthcare proxy for his mother, requests that all information regarding her care be told to him and not to inform his mother if any serious conditions are found. The son also requests that she not receive treatment for cancer if it is found, as he states it will only bring her anxiety and uncertainty about what will happen.

Exam results indicate that Mrs. Ahmadi has pancreatic cancer and that chemotherapy can prolong her life. Dolores arranges for translation services to be provided at the bedside when the provider arrives to relay the findings. The provider informs Mrs. Ahmadi that the disease that has been discovered requires decisions regarding treatment. The provider asks Mrs. Ahmadi if she would like to make the decisions on her own or if she would prefer that her son be given the information and make medical decisions on her behalf.

After contemplating for a moment, Mrs. Ahmadi states that in her culture the male head of the family makes decisions about healthcare for the women. She says that she trusts her son and that she wants him to receive the information and make the decisions regarding her own care.

Dolores and the provider respect Mrs. Ahmadi's autonomy and arrange for the son to be legally designated Mrs. Ahmadi's healthcare proxy (Varkey, 2021).

BENEFICENCE

The concept of beneficence is based on positive requirements by benefiting patients and providing good care. Beneficence is demonstrated by striving for the best outcome for clients, such as:

- Protecting clients
- Preventing harm
- Removing conditions that could cause harm

- Assisting individuals with disabilities
- Helping individuals in danger
(Varkey, 2021)

In the context of a client–case manager relationship, beneficence entrusts a case manager with performing professional duties in a competent, caring manner that will benefit the client.

NONMALEFICENCE

Nonmaleficence is an ethical obligation for case managers to avoid causing harm to clients. This may mean carefully weighing potential benefits against potential negative results or side effects that may result from providing case management services and then choosing the best course of action that will benefit the patient the most (Varkey, 2021).

CASE

Yolanda, a nursing case manager, receives a call from Mr. Smith. His wife has been a client of Yolanda's for the past year. Yesterday, Mrs. Smith was admitted to the intensive care unit for acute liver failure. Mrs. Smith is not responsive and has been diagnosed with a slow internal hemorrhage. She is a Jehovah's Witness, and prior to becoming unresponsive, she expressed in writing that she does not want to receive a blood transfusion under any circumstances, as it is a violation of her personal beliefs.

On the phone, Mr. Smith is distraught and tells Yolanda that the resident hospitalist is insisting that Mrs. Smith receive a blood transfusion. Mr. Smith says he tried to explain to the hospitalist that a blood transfusion would be detrimental and would violate his wife's spiritual values and beliefs. However, the hospitalist has been insistent that Mrs. Smith receive the blood transfusion to save her life.

Yolanda contacts the hospitalist and requests to speak with him. She explains that being a Jehovah's Witness means that Mrs. Smith believes she will not be allowed into heaven if she receives a blood transfusion. The nurse points out that the family are aware of this and wish to respect her beliefs. Yolanda also points out that the blood transfusion is of questionable clinical benefit because the patient has progressed to the final stages of liver failure. The transfusion may prolong her life, perhaps for a few days, but would represent an instance of ethical maleficence in the process.

Yolanda is advocating for her client using the ethical principles of autonomy, beneficence, and nonmaleficence. After hearing the explanation, the hospitalist cancels the order for the blood transfusion and apologizes to the family. Mrs. Smith dies the next day without experiencing an unnecessary violation of her expressed beliefs (Johnstone, 2023).

JUSTICE

Justice refers to the ethical responsibility to, as much 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 (CCMC, 2023).

Different conceptions of justice include:

- Equity justice (i.e., fairness and impartiality)
- Distributive and redistributive justice (i.e., equitable distribution of benefits and burdens)
- Restorative justice (i.e., reconciliation and reparation)
(Johnstone, 2023)

Examples of **ethical dilemmas** that arise around the principle of justice include:

- The allotment of scarce resources such as equipment, medical tests, medications, and organ transplants
- The care of patients who do not have insurance
- How to allot time to each case (e.g., giving equal time to each client or allotting time based on need, complexity, or socioeconomic status)
- Conflicts of interest (e.g., selecting a more expensive treatment option over an equally effective cheaper option because it benefits the clinician financially or otherwise)
(Varkey, 2021)

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 (McNamara, 2023).

Ethical Dilemmas

An ethical dilemma is a conflict between choices that, no matter which choice is made, some ethical principle will be compromised. How to determine what is morally "right" is rarely straightforward.

A case manager who encounters an ethical dilemma at work is confronted by the following three basic questions:

- What should I do?

- What is the morally "right" thing to do?
- How do I ensure that my actions are morally "right"?
  (Johnstone, 2023)

Resolution of ethical dilemmas requires careful evaluation of all the facts of a case, including following applicable laws, consulting with all concerned parties, and appraising the decision makers' ethical philosophies.

In order to resolve an ethical dilemma in the best possible way, several steps should be taken. These include:

1. Consider the consequences of both choices, particularly the positive and negative results from each.
2. Consider the actions of those choices. Do one's actions line up with the moral principles regarding honesty, fairness, and respect for other people?
3. Decide what to do and explain one's reasoning to those who are affected by the decision.
   (Hegde, 2023)

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. Williams, an 86-year-old patient who experienced 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. Williams 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. Williams's discharge will not cause him harm (nonmaleficence).

She enters the patient's room to assess his condition and to talk to Mrs. Williams. 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. Williams could still, with minimal help, get himself out of bed, check his own blood sugars, and give himself insulin to manage his diabetes. He could swallow and eat independently and use 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. Williams 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. Williams is an appropriate candidate to receive hospice services.

Two hours later Jennifer returns to Mr. Williams's room accompanied by a hospitalist and Dwight, the social work liaison from the hospice agency, to talk with Mrs. Williams. They start by acknowledging the difficulty of the situation and identify Mrs. Williams as the one who will make the final decision from among the possible options. Also in her 80s and with a chronic health condition, Mrs. Williams says she understands that her husband is not likely to recover and so she would like to take him home to a familiar place. Jennifer explains to Mrs. Williams the much greater difficulties in caring for her husband now that he is bed-bound and unable to do anything for himself. Mrs. Williams 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. Williams'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. Williams will need. Hospice states it can admit Mr. Williams that afternoon and will have another nurse case manager and home health aide visit to help Mrs. Williams 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 son.

Jennifer is satisfied that she has made the best decisions to ensure the discharge is safe while also adhering to ethical principles. She charts what has transpired.

THE CODE OF PROFESSIONAL CONDUCT FOR CASE MANAGERS

[Material in this section is excerpted from the Commission for Case Manager Certification's *Code of Professional Conduct for Case Managers with Standards, Rules, Procedures, and Penalties.*]

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 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 April 2023 (CCMC, 2023). 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 "Code of Ethics for Nurses" below and "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, 2023)

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, 2023)

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 that 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, and justice. (See also “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

1. **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.
2. **Competence.** Case management competence is the professional responsibility of the CCM and is defined by educational preparation, ongoing professional development, and related work experience.
3. **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.
4. **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.
5. **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.
6. **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.
7. **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.
8. **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 and Professional Conduct Committee.

CASE

Darius D'Souza, RN, is a board-certified case manager employed by 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 physician 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. Jacobs's physician's office to let them know about Mr. Jacobs's 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's physician'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's physician. Today he gets through to the nurse, lets her know about Mr. Jacobs's missed visits, and documents the call properly.

SECTION 3: CASE MANAGER/CLIENT RELATIONSHIPS

9. **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.
10. **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.
11. **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

12. **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.
13. **Disclosure.** CCMs will inform the client that information obtained through the relationship may be disclosed to third parties, as prescribed by law.
14. **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, or marketing, unless a lawful, written release regarding this use is obtained from the client or legal representative.
15. **Records.** CCMs will maintain client records, whether written, taped, computerized, or stored in any other medium, in a manner designed to ensure confidentiality.
16. **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.
17. **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

18. **Testimony.** CCMs, when providing testimony in a judicial or nonjudicial forum, will be impartial and limit testimony to their specific fields of expertise.
19. **Dual relationships.** Dual relationships can exist between the CCM and the client, payor, employer, friend, relative, research study, or other entities. All dual relationships and the nature of those relationships must be disclosed by describing the role and responsibilities of the CCM.
20. **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
21. **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.
22. **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 or results.
23. **Solicitation.** CCMs will not reward, pay, or compensate any individual, company, or entity for directing or referring clients, other than as permitted by law or corporate policy.
24. **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.
25. **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 an 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.

SELF-REPORTING CODE VIOLATIONS

In addition to complaints filed from clients, the Commission receives and processes self-reports of CCMs who are self-reporting possible violations of the Code. Self-reports must be signed, notarized, and written on the Self-Report Form attached to the Code of Professional Conduct for Case Managers (see also "Resources" at the end of this course). The self-report cannot be longer than 10 pages, excluding supporting documentation.

After a self-report is submitted by a CCM, the Committee reviews it and determines whether the report contains sufficient information that the CCM's actions violated the Code. If the Committee needs more information, they may ask for additional information from the CCM or may choose to request an interview with the CCM to gather more information. The CCM may decline to participate in the interview without repercussions. The CCM may also request to meet with the Committee to make a statement and answer questions from the Committee. During interviews or requested meetings, the CCM is permitted to have legal counsel or another representative present as an advisor. Transcripts of interviews or meetings will be made and preserved by the Committee, and no other party is permitted to record.

The Committee will then meet to deliberate and come to a decision in a closed session, along with the legal counsel that may be advising the Commission. Decisions of Code violations must be supported by substantial, objective, and believable evidence. Decisions are made when a quorum is present, and only members who participated in the closed session are allowed to vote. If there is not sufficient evidence that the CCM violated the Code, then the case will be closed and the CCM will be notified in writing. If there is sufficient evidence that the CCM violated the Code, the Committee must decide what actions or sanctions will be imposed. Consideration will be made during the decision for the fact that the CCM chose to provide a self-report. The CCM is permitted to make a written appeal, if they choose to do so, within 30 days of the committee's decisions.

SANCTIONS FOR CODE VIOLATIONS

If it is determined that the Code has been violated, the committee may apply sanctions against the CCM. Prompt written notice of such sanctions will be given to the CCM regardless of whether they self-reported or received a complaint from another individual.

Depending on the severity of the violation, sanctions may include:

- Reprimand
- Probation
- Suspension
- Revocation of CCM certification
  (CCMC, 2023)

Issued sanctions may be conveyed to professional licensure, certification, or registry boards once an appeal has been dismissed or the time for appeal has expired.

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 (ANA, 2015). The provisions of this code listed below 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."

This first provision states that nurses must respect the autonomy and inherent worth of all individuals and their families and remain professional throughout all interactions. Nurses must also educate themselves and abide by professional guidelines throughout communication and work with both clients and colleagues (Haddad & Geiger, 2023).

PROVISION 2

"The nurse's primary commitment is to the patient, whether an individual, family, group, community, or population."

The second provision highlights the fact that the patient's (or client's) needs always come first. The nurse must be aware that patient care is individualized to the patient's needs as much as possible. Conflicts of interest that arise must be acknowledged and addressed in order to not affect the care of the patient. Collaboration between interprofessional teams improves patient care, and professional boundaries are important (Haddad & Geiger, 2023).

PROVISION 3

"The nurse promotes, advocates for, and protects the rights, health, and safety of the patient."

Provision three highlights the nurse's role to act as the patient's advocate. To do this, nurses must maintain confidentiality and be aware of privacy guidelines that are set forth in policies and procedures to protect patient's privacy. Competence regarding professional standards must be demonstrated initially and throughout a nurse's practice. Nurses must report witnessed questionable healthcare practice to the appropriate authority in order to protect the patient. Patient care must not be provided by a nurse under the influence of any substance that alters their ability to make competent decisions (Haddad & Geiger, 2023).

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.”

Responsible decision-making is the cornerstone of Provision 4. Nurses must use their authority in a professional way that centers on the patient. Nursing actions must be carefully planned and implemented in a responsible manner. Delegation must be done appropriately and with the intent for the best outcome for the patient (Haddad & Geiger, 2023).

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 5 highlights self-care, which is an important aspect of caring for others. Effective nurses must practice integrity at home and while practicing nursing. Nurses must strive to further their education and grow professionally. Changes or trends in current practice are adopted in order to remain competent and grow in the profession (Haddad & Geiger, 2023).

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 healthcare.”

This provision emphasizes the importance of the nurse understanding safety, quality, and environmental considerations that improve outcomes for the patient. Ethical obligations that are not upheld during the provision of care must be reported to the appropriate authority (Haddad & Geiger, 2023).

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.”

The main aspect of provision seven is that every nurse must know how to apply evidence-based practice to their own individual practice. Nurses must also participate in research, committees, and board memberships in order to improve health policy and professional nursing standards (Haddad & Geiger, 2023).

PROVISION 8

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

Provision 8 explains that nurses must promote the concept that health is a human right for all individuals. Nurses continually learn and prepare for advances in care of patients. Nurses act as diplomats and advocate for patients when presented with unusual situations across various healthcare settings (Haddad & Geiger, 2023).

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."

In Provision 9, nurses are encouraged to participate in committees and groups that advocate for social justice and increase political awareness of the nursing profession. Nurses can influence health policy when they collaborate as a unified voice (Haddad & Geiger, 2023).

LEGAL CONCEPTS AND STATUTES

Case managers practice within a society governed by 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 laws to ethics in the practice of case management.

[H3] Types of Law

Although the terms *laws* and *ethics* are distinct from one another, some individuals mistakenly assume they mean the same thing. In the United States, *law* refers to "a rule of conduct or action prescribed or formally recognized as binding or enforced by a controlling authority" (Merriam-Webster, 2024b). A simplistic explanation of law is that it is the command of a government that is backed by a threat or sanction if it is not complied with (Johnstone, 2023). Case managers must practice according to the laws that govern their society as well as their individual practice.

There are two major divisions of law: civil and criminal.

- **Civil law** pertains to the private rights of one or more individuals and provides a means by which individuals may seek to enforce their rights against other individuals. Some types of civil law include contract law, wills, family law, and trusts. Civil litigation that involves injury (due to assault, battery, negligence, professional negligence, etc.) is called a *tort.*
- **Criminal law** regulates the conduct of the individual in order to protect the public and society as a whole. Criminal prosecution is initiated by the government as opposed to an

individual. The main types of criminal offenses are felonies, misdemeanors, and infractions. The primary goal of criminal litigation is to determine whether to punish the defendant.
(St. Francis School of Law, 2021)

TYPES OF LAW	
Civil Law	
Function/Goal	To redress wrongs and injuries suffered by individuals
Types	• Contract law • Wills • Family law • Trusts • Torts (involves injury due to assault, battery, negligence, professional negligence, etc.)
Proof	By preponderance of evidence; adjudicated by a judge or jury; a jury decision need not be unanimous
Criminal Law	
Function/Goal	To regulate individual conduct for the good of society as a whole; to punish the defendant (if found guilty)
Types	• Felonies (most serious crimes such as manslaughter, murder, rape, etc.) • Misdemeanors (lesser offences such as simple battery, first DUI offense, violation of licensed professional practice act, etc.) • Infractions (petty-level crimes usually not punishable by imprisonment, such as speeding, parking violations, etc.)
Proof	Beyond a reasonable doubt; jury decision must be unanimous (except in Oregon)
(St. Francis School of Law, 2021)	

ETHICS AND THE LAW

The distinction between ethics and the law becomes clearer when using historical examples in which the law required actions that ethics rejected. Laws enforced during times of war include laws that were created by the Nazi regime during World War II, such as antisemitic legislation that made persecution of the Jews legal. Although this was considered law at the time, it was certainly not ethical. If ethics and the law were considered the same, then individuals would feel no compunction to regularly enforce laws that violate ethical principles (Johnstone, 2023).

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 later amendments)
- 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, first enacted in 1990, is a broad-reaching civil rights statute. Amended in 2008 to broaden protections for workers with disabilities, with additional revisions in 2010 and 2016, 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 (ADA.gov, n.d.).

HEALTH INSURANCE PORTABILILTY 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 preexisting 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 their 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 (HHS, n.d.).

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, and 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 state's 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's practice act may have language that differs from other states in regard to evaluations/reevaluations, 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 act. 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 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 also "Resources" at the end of this course.)

CASE

Jing Wu is a social worker case manager who practices 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 teenage son has 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. 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 very supportive and knew Jing to be a conscientious 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 would need to call the state board in order to explain the situation and to determine if Jing 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 contract 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 (St. Francis School of Law, 2021).

A contract is an agreement that is enforceable by law, created by oral or written consent of the parties. Contracts may include obligations imposable by law even if one or more parties are not aware of those obligations.

Breach of contract is a failure (without legal excuse) to perform any promise that forms all or part of a contract. This includes failure to perform in a manner that meets the standards of the industry or the requirements of any express warranty or implied warranty. One or both parties violating a written agreement (such as an employment agreement between a healthcare agency and a case manager) may constitute a breach of contract (Cornell Law School, n.d.).

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.
  (Cornell Law School, 2022a)

Intentional Torts

ASSAULT AND BATTERY

Assault is doing or saying anything that makes people apprehend harmful or offensive contact without their consent. The key element of assault is apprehension of contact, for example, threatening to force a resistant client to get out of bed against their 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 (Cornell Law School, 2022a).

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 they have 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

FALSE IMPRISONMENT

False imprisonment is a tort offense that involves restraining or confining a competent person against their will. Some examples of false imprisonment are:

- Restraining (physically, pharmacologically, etc.) a client for non–medically approved reasons
- Detaining an unwilling client in the hospital, even after the client insists on leaving
- Detaining a person who is medically ready for discharge for an unreasonable period of time
  (Cornell Law School, 2022b)

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 case managers: 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 (Cornell Law School, 2023).

NVASION OF PRIVACY

Invasion of privacy includes intruding into aspects of a client'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 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.

That night, Agnes filled out the Self-Report Form available on page 18 of the Code of Professional Conduct for Case Managers. She signed the Self-Report Form and made a plan to get it notarized the next day before she mailed it to the address of the Ethics and Professional Conduct Committee.

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.

Agnes received a call from the CCMC Committee to set up an interview regarding her self-report. After the interview, the Committee came to the conclusion that Agnes did violate the Code. They issue a reprimand in the form of a written statement and imposed that Agnes be required to take a 4-credit-hour course about ethics as part of her remediation (CCMC, 2023).

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 their own use, such as when an employee appropriates funds from a company bank account (Cornell Law School, 2022c).

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 NEGLIGENT 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 negligent action involves questionable intent (such as physically pulling a resistant patient 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.
   (Maloney Law Group, 2023; Osmond, 2023)

CASE

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

Reading the patient's chart on Friday, 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 this 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 on Friday afternoon to set up a Saturday home visit, the patient says she is very tired after leaving the hospital that morning 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 Ms. 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 realizes 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 their 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 their 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 they supervise.
- **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, 2016)

- **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.

PROFESSIONAL LIABILITY INSURANCE

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.

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 they are 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 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

Legal issues in healthcare are set by federal and state laws, and ethical issues are concerned with what is the "right" thing to do. Acknowledging and acting on the wishes of the patient being treated are a critical component of legal and ethical care (Shah et al., 2023). While not all jurisdictions provide specific legal protections for all individuals, healthcare professionals and institutions can discuss and address various legal issues with patients.

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. Advance directives usually name another person chosen to be a person to make healthcare decisions for them when they are no longer able to make decisions for themselves.

Federal law (the Patient Self-Determination Act) requires hospitals to inform patients that they have the right to complete an advance directive. Advance directives are regulated by state law and therefore differ from state to state.

Such documents usually address the patient's wishes regarding:

- Cardiopulmonary resuscitation (CPR)
- Intubation/mechanical ventilation (do not intubate, or DNI)

- Artificial nutrition/hydration (ANH)
- Dialysis
- Antibiotic or antiviral medications
- Comfort care (palliative care)
- Organ and tissue donations

Approximately 45% of Americans have advance directives or living wills. Older patients with chronic disease(s) are especially encouraged to have advance care planning in place (Jones, 2020). The use of advance directives varies according to race and ethnicity. According to the American Psychiatric Association, Asian and White patients are more likely to have advance directives than patients of other racial or ethnic backgrounds. Many patients may feel that advance directives are not necessary because family and physicians should already know what their wishes are (McDarby, 2024).

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. When asked about having to make a decision about removing life support for a family member, 25% of adults surveyed asserted they had been in this situation. Particularly in the case of chronic illness in which 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 (Jones, 2020).

A video can also be made explaining the patient's precise wishes, although this is not a legally compelling document.

Healthcare professionals have an obligation to work with patients and their families to reach decisions that balance autonomy and beneficence. However, healthcare professionals are legally constrained from witnessing an advance directive if they are an employee of the organization in which the patient's wishes will be enacted.

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*. Living wills and medical or durable powers of attorney predate advance directives but may still be in use among older patients, and healthcare workers should be able to distinguish among the various forms.

A **living will** is a document written while alive to dictate preferences for healthcare decisions. It addresses personal preferences regarding the above-mentioned life-sustaining measures and under what circumstances the patient would prefer those measures be performed or withheld.

A medical or **durable power of attorney** (DPOA) names one or more people who may make decisions for the person who is unable to make their own wishes known. Referred to as a *healthcare proxy* (representative, agent, or surrogate), this person is named on the advance directive form. It is essential that a very specific conversation take place between the patient and the person named in the DPOA to ensure that there is clear understanding about the patient's final wishes (NIA, 2022).

In a situation where a patient is unable to make an independent decision but has not designated a decision maker, state law hierarchy must be consulted to determine who should be the legally authorized representative. Many states have ordered lists, such as: parents of minors, spouse, adult child of senior, next-of-kin, even down to "close friend." Some states designate an ethics committee to serve as a proxy. If the search for a legally authorized representative is unsuccessful, a legal guardian may be appointed by the court (Medicare Interactive, 2023).

CASE

A 79-year-old patient with metastatic breast cancer has decided to stop chemotherapy and wants simply to be made "as comfortable as possible." She tells her healthcare team that the side effects of treatment are unbearable and that it is time to take back control of her life.

The patient's family members, however, are adamant that she continue her treatment. They explain to the patient's healthcare provider that she has been showing signs of dementia and "doesn't really know what she wants." The patient does not have a living will and has given one of her children power of attorney.

This situation can cause a significant ethical dilemma. Questions to ask include:

- Is the patient legally competent?
- What rights do family members have regarding their loved one's care?
- What are the potential consequences of stopping treatment?
- What are the consequences of continuing treatment?

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, 2022). 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, CPR, comfort measures, and mechanical ventilation/respiration.

Such a document is intended for those who have already been diagnosed with a serious illness; however, it does not replace other directives. Instead, it serves as physician-ordered instructions

(similar to a prescription) to ensure that, in case of an emergency, the patient receives the treatment preferred. The document also indicates which advance directives have been created and who is the legal healthcare representative (House et al., 2023).

The form is printed on brightly colored paper and stays with the patient during transfers from one care setting to another. Patients at home are instructed to keep the POLST form on the refrigerator, where emergency responders can easily find it. Long-term care facilities retain POLST forms in residents' charts.

In some states, the Medical Orders for Life-Sustaining Treatment (MOLST) form is used instead of the POLST form. The two forms are very similar. The main differences are in the wording related to intubation or nonintubation (NI), the degree to which resuscitation measures will be carried out, and the position on the use of comfort measures (Lambert, 2022).

(See also "Resources" at the end of this course.)

DO-NOT-ATTEMPT-RESUSCITATION (DNAR) ORDERS

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

Patients and families must 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 explain that withholding CPR does not equate to letting someone die. Rather, a DNAR order can be considered an "allow natural death" (AND) order (Whidbey Health, 2024).

The primary care provider discusses the possibility of a DNAR order as soon as it is reasonable and while the patient is still able to make decisions. A delay in putting a DNAR order in place may result in treatment unwanted by the patient and in 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. In the facility where the patient is admitted or resides, specifics of the order are also carefully documented in the patient's chart.

If the patient's preferences are not known at the time of a cardiopulmonary arrest, then resuscitation must be initiated. The resuscitation may then be stopped if it is learned that it is not keeping with the patient's wishes (AMA, n.d.).

MECHANICAL VENTILATION (MV)

Mechanical ventilation is achieved by the introduction of an endotracheal or tracheostomy tube into the patient's trachea. This provides an artificial airway through which air under pressure and oxygen can be used to simulate breathing. If the cause of a patient's inability to breathe adequately is temporary, such as pneumonia, use of MV can prolong life long enough for the needed treatment, such as antibiotics, to be provided.

Decisions about mechanical ventilation may be spelled out in a 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 (NIA, 2022). 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.

Decisions about whether to have ANH involve weighing the potential benefit with the burden to the patient. The American Nurses Association position statement supports a patient's (or surrogate's) right to weigh the risks, benefits, and burdens of ANH after a full discussion with the healthcare team (ANA, 2017). The ANA position statement thereby 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 (Heuberger & Wong, 2019).

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 (NIA, 2022).

The potential burdens of ANH depend on the route of administration and may include sepsis (with total parenteral nutrition), aspiration (especially with tube feedings), diarrhea (also with tube feedings), pressure ulcers and skin breakdown, and complications due to fluid overload. Demented or confused patients receiving ANH may need to be physically restrained to prevent them from removing a gastrostomy tube, nasogastric tube, or central intravenous line. Pain, epistaxis (with a nasal feeding tube), pharyngitis, esophagitis, and airway obstruction may also occur. Many health professionals believe that hospice care with cessation of feeding and fluids is a more humane alternative to ANH (Heuberger & Wong, 2019).

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. Without ANH, in fact, 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 or ice chips.

Clinicians can help families understand that forgoing ANH is not "killing" or "starving" the patient. Communication among the nurses and physician writing orders and taking care of the patient and those making decisions about care should guide the decisions made regarding ANH. One of the important considerations is the patient's religious or spiritual beliefs. Communication with family or surrogates with these fears can help assuage worries that the patient is "starving to death." It is significant for them to know that inability to eat and drink is a natural part of dying (Akdeniz et al., 2021; Heuberger & Wong, 2019).

CASE

Kathy, a hospice nurse case manager, was questioned by the family of an elderly patient on hospice care in the nursing home where she worked. When the discussion turned to a decision about providing artificial nutrition and hydration 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 gently explained to family that studies have shown no benefit in giving tube feedings or intravenous therapy to dying patients and that these measures could, in fact, cause additional pain and other burdens, such as aspiration or diarrhea, for their loved one. Kathy assured the family that the nursing staff would continue to keep the patient comfortable, give her pain medication when needed, and provide mouth care and moisten her mouth with ice chips to keep it from feeling dry.

The Right to Die

The right-to-die movement in the United States 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 dose of drugs, the drugs themselves, or other measures—by a patient or a person who has knowledge of the patient's intention.

According to the American Nurses Association Code of Ethics (last updated in 2015), 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 (ANA, 2015).

Case managers may be confronted with requests for assistance in dying. However, as of 2021, this practice is legal in only a few jurisdictions.

- In 1997, Oregon became the first state to pass right-to-die laws.
- Washington (2008) and Montana (2009) soon followed. While the law in Montana does not allow a specific PAD or right-to-die procedure, it states that assistance does not violate any current state laws.
- In 2013, the Vermont legislature passed a right-to-die law by a 75–65 vote. The guidelines for practice are very stringent.
- In 2016, California became the fifth state to pass a right-to-die 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 as being terminal within six months and mentally capable of making the decision. The California law passed after much debate, advertising on both sides, and input from healthcare providers, parents of terminally ill children, and religious leaders.
- Other jurisdictions that have adopted physician-assisted suicide (PAS) or right-to-die laws include Colorado (2016); Hawaii (2018); Washington, DC (2018); Maine (2019); New Jersey (2019); and New Mexico (2021).
  (Charlotte Lozier Institute, 2021)

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 (Faris et al., 2021).

CASE

John Kahele is a nurse who has been working in hospice case management for the past six years. Personally, he views euthanasia as morally justified to relieve intractable suffering. However, he practices in a state where right-to-die laws have not been passed. He is also aware of the ANA Code of Ethics provision that stipulates that nurses may not act with the sole intent to end a patient's life, regardless of whether they are motivated by compassion, autonomy, or quality of life considerations.

John receives a phone call from a patient with Stage IV pancreatic cancer. The patient has been enrolled in hospice services for the past month. She expresses frustrations to John regarding her pain and her feelings of being a burden to her husband, who has been her caregiver since her diagnosis. She says she saw a documentary about physician-assisted suicide and asks John if there is a way she can request this for herself.

Although John personally finds voluntary euthanasia morally justified, he does not express this to the patient. He explains that this is not an option in the state in which they reside. He expresses concern about her lack of pain management and sets up a visit with the hospice nurse for that afternoon.

John's decision to not assist the patient with voluntary euthanasia is considered a legal decision that is legally defensible as opposed to a moral or clinical decision. John's decision is influenced by considering the legal consequences that may occur (loss of his nursing license, criminal charges) if he complies with the patient's request as opposed to the moral consequences of not complying with the patient's request (Johnstone, 2023).

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.

Organ procurement organizations (OPO) throughout the country facilitate the donor organ recovery process, which increases efficiency and organ yield, reduces costs, and minimizes organ acquisition charges. OPOs have taken on the responsibility of harvesting donor organs and matching them with potential recipients (NFT, n.d.).

In the United States, the growing disparity between organ availability for transplantation and the number of patients in need has challenged the donation and transplantation community. The number of organs available for transplantation has been a relatively fixed national resource over the last decade. By contrast, the national waiting list rises by thousands each year, with only a fraction of those waiting receiving lifesaving transplants. In 2022, 17 people died every day while on a waiting list for one or more transplanted organs.

One organ donor can save up to eight lives and save or improve an additional 50 lives through tissue donation. There were over 42,000 organ transplants performed in the United States in 2022, while 103,327 individuals were awaiting transplants during that time (HRSA, 2023).

Transplant surgery is expensive. It typically isn't planned until the patient shows proof of possession of 20% of the cost of the surgery as a copay.

Most organ donations come from deceased donors, although a living donor can donate as well. Tissues can also be transplanted.

MOST COMMON ORGANS AND TISSUES TRANSPLANTED IN THE UNITED STATES

Organs

- Heart
- Lungs
- Liver
- Intestines
- Kidneys
- Pancreas

Tissues

- Heart valves
- Bone
- Cornea
- Skin
- Ligaments
- Tendons
- Cartilage

(CDC, 2022a)

DISCUSSING ORGAN DONATION

The public has a generally favorable attitude about organ donation for transplants; however, not every clinician broaches the subject with patients since they may be perceived as being more an advocate for the organ recipient than of their patient. Ideally, questions about organ donation are discussed with the patient in the context of advance directives. This relieves the family of

making the decision during the stressful time immediately after death. Unless the patient has documented the wish to become an organ donor, the family must decide.

The Anatomical Gift Act was approved by the U.S. Congress in 1968 following the first heart transplant the previous year. The 2006 United States Revised Anatomical Gift Act compels hospitals and OPOs to pursue donation in cases of brain death in designated donors to stimulate the supply of available organs (Schiefer, 2019). Federal law requires that only a "designated requestor" may approach the family about organ donation (see box below).

DONATION AFTER BRAIN DEATH

Brain death statutes in the United States differ by state and institution. The Uniform Determination of Death Act (UDDA) of 1981 provides states with whole-brain criterion of death (Find Law, 2023). The UDDA offers two definitions for when an individual may legally be declared dead:

1. Irreversible cessation of circulatory and respiratory functions, or
2. Irreversible cessation of all functions of the entire brain, including the brain stem

When brain death has been confirmed, the hospital notifies the local organ procurement organization. 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.

DONATION AFTER CARDIAC DEATH

Anyone who has brain function that has been deemed incompatible with life but who does not meet all criteria for brain death is a potential candidate for donation after cardiac death (DCD). DCD may be discussed as an option with families when they have accepted that their loved one cannot survive and have made the decision to remove that person from life support. There is a 90-minute time frame in which organs can be recovered after extubation to the pronouncement of death. If the patient does not progress to cardiac death within this time, organ donation cannot occur. Tissue donation may still be an option after death.

If the family agrees to DCD, the patient is removed from the ventilator in an operating room. When the heart stops beating, a physician declares death, and organs are recovered (Donor Alliance, 2024).

DESIGNATED REQUESTORS

It is a federal regulation that a specially trained, designated staff member known as a *designated requestor* approach the family to discuss the option of organ donation. A designated requestor may be a case manager, social worker, nurse, or other healthcare professional who has completed a course approved by an OPO on how to approach potential

donor families to request organ or tissue donation. Who this person is varies according to the facility.

When the patient is registered to be an organ donor, it is the requestor who lets the family know and who explains how those wishes will be carried out after death is pronounced. The family is also given clarification of the definition of brain death and informed that the patient will remain on life support after death is pronounced (ODTA, 2020).

MEDICAL EVALUATION OF POTENTIAL DONORS

Screening of a potential donor is essential to determine whether the donor has an infection that could be transmitted to recipients through transplanted organs or tissues. The Organ Procurement and Transplantation Network policies (for OPOs) and FDA regulations and guidance (for tissue and eye banks) require a medical and social history interview to be conducted with the deceased donor's next of kin or another knowledgeable person (CDC, 2022b).

Interviews are designed to assess the donor for:

- Risk behaviors that may have exposed the donor to certain diseases
- The donor's past medical history
- Relevant travel history (which can be important for exposure to certain pathogens)

OPTN policy requires OPOs to perform the following **tests** to determine if the donor has certain infections:

- Human immunodeficiency virus (HIV)
- Hepatitis B virus (HBV)
- Hepatitis C virus (HCV)
- Syphilis
- Cytomegalovirus (CMV)
- Epstein Barr virus (EBV)
- Toxoplasmosis
  (CDC, 2022b)

Once a potential donor has been evaluated and accepted, additional assessments are done for the donation of specific organs.

THE MATCHING PROCESS

Following medical evaluation for contraindications, the OPTN is contacted by the OPO in order to begin a search for matching recipients. The OPTN matching process includes:

- Blood type
- Body size
- Severity of patient's medical condition
- Distance between the donor's hospital and the patient's hospital
- Patient's waiting time
- Whether the patient is available
- Tissue type
(HRSA, 2022)

ORGAN RECOVERY

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, or ambulances to the hospital where the transplant recipient is waiting and may be prepped and ready in the OR (HRSA, 2022).

LEGAL DECISION-MAKING AUTHORITY

An important barrier to organ and tissue 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 they have indicated their 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." Research does not indicate a clear consensus on whether an opt-out system results in increased donations over an opt-in system.

The uniform Anatomical Gift Act of 2006 provides the legal framework for determining consent for organ donation. Most 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 (USLegal, 2024).

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:
    - Lack of commitment on behalf of healthcare professionals to the process
    - Lack of knowledge regarding how to carry out the brain death protocol and doubt about when to begin the process
    - Resistance to starting the brain death protocol due to personal difficulties dealing with death
      (YazdiMoghaddam et al., 2020)

CASE

Aaliyah is a registered nurse who has recently started a case management training program. Today she is shadowing Kevin, a transplant nursing case manager with five years of experience. Aaliyah and Kevin are going over the paperwork for a 19-year-old female admitted to the ICU who has just been diagnosed with brain death following a motor vehicle accident and has been identified as a potential candidate for organ donation.

Kevin explains that now that brain death is confirmed, he will notify the local organ procurement organization. If the patient is a potential donor, a representative of the OPO will immediately come to the hospital as the designated requestor per the hospital's policy. The representative will search for legal consent in the donor registry or request consent from the patient's parents.

Aaliyah asks Kevin how the diagnosis of brain death has been confirmed. Kevin explains that the patient has irreversible cessation of all functions of the entire brain, including the brain stem. Aaliyah says it is hard for her to wrap her head around the fact that the patient's heart is still beating even though the patient has been diagnosed as brain dead.

Kevin understands healthcare professionals who are new to the organ donation process can have difficulty accepting brain death as death since the patient's heart is still beating. He patiently explains that brain death is the termination of all functioning of the entire brain and cannot be reversed. Kevin tells Aaliyah that the American Academy of Neurology indicates that brain death can consist of a coma, no brainstem reflexes, and the cessation of breathing. The American Medical Association defined brain death in 1980 through the Uniform Determination of Death Act, which is considered the legal standard for death. Even though the brain is considered dead, the human body can be kept alive with ventilators, medication, and

artificial nutrition to keep the body functioning until the organs are procured (Find Law, 2023).

Aaliyah indicates she now has a greater understanding of brain death now that Kevin has explained it in detail to her. Kevin then explains how transplant case management will coordinate services to get the procured organs where they need to go in a timely manner.

ETHICS AND INVOLUNTARY HOSPITALIZATION 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 hospitalized ("committed") for treatment.

Involuntary hospitalization 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 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 three to five days. If the person is not discharged on or before the three- to five-day limit because more treatment is necessary, a court order may be sought to extend the involuntary commitment (Fariba & Gupta, 2023).

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 they are 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 examples 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 (Varkey, 2021).

Evidence is accumulating about **harms** inherent in civil commitment. Three arguments include:

- Inadequate attention has been given to the harms resulting from the use of coercion and the loss of autonomy.

- Inadequate evidence exists that involuntary hospitalization is an effective method to reduce deaths by suicide.
- Some suicidal patients may benefit more from therapeutic interventions that maximize and support autonomy and personal responsibility.
  (Borecky et al., 2019)

INSURANCE COVERAGE FOLLOWING SUICIDE OR ATTEMPTED SUICIDE

There are federal protections to ensure that most health insurance plans will pay for medical care resulting from a suicide attempt. There are, however, many forms of health insurance, and some plans may expose people to substantial uncovered costs after an attempted suicide (NAMI, 2021).

Many people have life insurance policies. However, a suicide clause is a standard clause in life insurance policies that limits payments made to survivors of a policyholder who dies by suicide within a certain period after purchasing the policy. Insurance companies typically do not pay a death benefit if the covered person dies by suicide within the first two years of coverage, commonly known as the exclusion period.

When the exclusion period ends, the policy's beneficiaries can receive a death benefit if the covered person dies by suicide (Cornell Law School, 2021).

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

This perspective is centered on the idea of autonomy and generally rejects involuntary hospitalization because it:

- Takes away the person's freedom
- Restricts what the person can do with their 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 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.

EGALITARIAN-LIBERAL PERSPECTIVE

This ethical perspective emphasizes the equality of access to resources. This approach states that the government's role is to protect individual rights and that the right to health is a priority. But if the right to health is 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. However, the question remains as to how a mental health professional can know in advance that forcible treatment is justified, especially since there are no objective tests to verify whether a decision-impairing disease or disorder may or may not exist (Sandu et al., 2018).

CASE

Alex is a case manager who has recently been assigned to assist a patient named Grace, who has trigeminal neuralgia. Trigeminal neuralgia is characterized by severe unilateral paroxysmal facial pain and often described by patients as the "world's worst pain." Alex is familiar with this syndrome and its label as the "suicide disease" because, even though the disease isn't fatal, many afflicted with it take their own lives due to the intolerable and unbearable pain.

During their first visit, Alex quickly establishes rapport with Grace by using basic attending and listening skills. He reviews the disease process and describes what types of services Grace qualifies for. After performing Grace's initial evaluation, Alex asks her to be involved in setting some realistic and meaningful short- and long-term goals for her care.

At each visit, Alex engages Grace in conversation using open-ended questioning, during which he observes her and listens for red flags that may indicate suicidal thinking. During one visit, he notices that she has become more withdrawn, appears sad and listless, and begins to talk about how she doesn't think she can continue to deal with the pain much longer. Alex then asks her direct questions to screen her for suicide risk. After scoring the suicide risk assessment tool, he contacts her physician for follow up.

Alex's actions constitute a communitarian perspective, which holds that an intervention must take place to prevent Grace from harming herself.

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

Code of Ethics (National Association of Social Workers)
https://www.socialworkers.org/About/Ethics/Code-of-Ethics

Code of Ethics for Nurses (American Nurses Association)
https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/

Code of Professional Conduct for Case Managers (Commission for Case Manager Certification)
https://ccmcertification.org/about-ccmc/code-professional-conduct

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

Find Your Nurse Practice Act (National Council of State Boards of Nursing)
https://www.ncsbn.org/policy/npa.page

HIPAA general information
https://www.hhs.gov/hipaa/for-professionals/privacy/

National POLST Paradigm: State Programs
https://polst.org/programs-in-your-state/

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TEST

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1. Which statement is a broad definition of ethics?

a. Describes a set of moral principles that govern behavior
b. Protects society from actions that directly threaten its order
c. Punishes members of society for actions that are wrong
d. Organizes people to rise up and change society

2. Which ethical theory is practiced when a case manager considers a decision to be right because their motivation was good even though the client experienced negative consequences?

a. Deontological
b. Consequential
c. Teleological
d. Moral

3. Which ethical principle is a case manager violating when the care they provide is based on a client's race or ethnicity?

a. Nonmaleficence
b. Justice
c. Autonomy
d. Beneficence

4. Which statement describes the purpose of a code of ethics?

a. Establish laws for the practice of a profession
b. Describe standards of behavior of a profession
c. Serve as a substitute for a state practice act
d. Describe the scope of practice of a profession

5. Which statement is absent from the Code of Professional Conduct for Case Managers?

a. Obey all laws and regulations.
b. Place the public interest above one's own interest at all times.
c. Renew one's case manager certification every two years.
d. Always maintain objectivity in one's relationship with clients.

6. Which statement describes a provision of the Code of Professional Conduct for Case Managers?

a. May practice if convicted of a felony so long as the felony is unrelated to the practice of case management
b. May discriminate against a client if the client's sexual orientation is contrary to the case manager's religious beliefs
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

7. Which statement is **not** included in the Code of Professional Conduct for Case Managers?

a. A client will be given information by the CCM so they can be empowered to make their own decisions.
b. A formal discharge process must be followed, with notification to relevant parties.
c. A CCM will maintain objectivity in their relationship with their client and not enter into a relationship with them that would threaten that.
d. A CCM may encourage a client to check certain boxes when filling out an advance directive form.

8. Which offense occurs when a case manager who is a licensed professional violates a regulation of their state practice act?

a. Misdemeanor
b. Felony
c. Breach of contract
d. Infraction

9. Which federal law specifically addresses the rights of patients in regard to private and/or sensitive healthcare information?

a. Social Security Amendments of 1965
b. Americans with Disabilities Act of 1990
c. Health Insurance Portability and Accountability Act of 1996
d. Case Management Practice Act of 2008

10. Which statement describes the **goal** of a state practice act?

a. Create an administrative framework to define a profession
b. Ensure qualified supervision for licensed professionals
c. State the competency requirements of a profession
d. Protect the public by setting standards for professional practice

11. Which tort involves restraining a mentally ill client who is not a danger to self or others against their will?

a. Invasion of privacy
b. Fraud
c. Defamation of character
d. False imprisonment

12. Which term describes the action of a case manager who does not uphold the standards of care for a case management professional and makes a mistake that results in an injury to the client?

a. Intentional tort
b. Negligence
c. Criminal offense
d. Fraud

13. Which statement describes a medical or durable power of attorney (DPOA)?

a. End-of-life decisions are made by whichever adult family members are present when the patient becomes unresponsive.
b. A healthcare proxy is named in advance to make decisions for the patient once they are no longer able to do so.
c. The patient's primary care physician is empowered to decide what is best for the patient.
d. A formal diagnosis of a serious illness must be made prior to addressing any ethical decisions that arise involving patient care.

14. In which jurisdictions is physician aid in dying (PAD) legal?

a. All 50 states and the District of Columbia
b. Canada, but not in the United States
c. In a few U.S. states
d. Only with the permission of the dying patient's family

15. Which statement is **true** 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. Federal law requires that only a trained designator requestor may approach the family about possible organ donation from a deceased relative.

16. Which statement describes the egalitarian-liberal ethical perspective regarding involuntary hospitalization of a person at risk of suicide?

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 their 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 the broader community considers morally wrong and offensive.