

CASE STUDY

Ethical dilemma and resolution: a case scenario

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Abstract

This article illustrates an ethical dilemma that I faced while treating an 86-year-old woman at her home. The ethical dilemma was caused due to several factors such as the expectations of the client (client/ consumer rights), organisational expectations (employer, governmental and payer-source regulations) and my own personal values (one's moral philosophies, perceived social responsibilities, sense of professional duty) and how they all interact with each other. The case is a classic example of a seemingly simple yet frequent dilemma encountered by occupational and physical therapists in the United States serving clients who are covered by Medicare (the government's health insurance) for home health. The article is aimed at highlighting the various ethical principles involved in clinical decision-making, and it suggests methods for resolution of ethical dilemmas. Although the article is based against the backdrop of the US health care system, students and health care practitioners globally can relate to it.

The ethical dilemma in the case discussed below involved whether or not to continue treating a client who clearly needed occupational therapy services based on medical necessity, yet the payer-source (Medicare) coverage criteria for services to be delivered at home was questionable. That is, should one continue to treat the client and uphold the principle of beneficence yet run afoul of the law, or should one discontinue treating the client to uphold the law but possibly cause harm to the client?

The case scenario

Three years ago, Ms EH, an 86-year-old woman, was referred to me after a debilitating stroke affected her right side (pre-morbidly her dominant side). Ms EH was admitted under home health after running out of Medicare allowable days at a skilled nursing facility (SNF). Ms EH needed considerable assistance with all activities of daily living (ADL) and was primarily wheelchair-bound due to her inability to walk independently. She lived with her 88-year-old husband Mr. RH, who was also not in the best of health. Due to financial constraints the couple opted against long-term or assisted living placement in favour of their trailer home. Ms EH demonstrated good rehabilitation potential and progress with all her home health services.

One night, approximately three weeks after her return home from the SNF, Mr. RH suffered a massive myocardial infarction. He was hospitalised and underwent cardiac catheterisation. It indicated diffuse blockage of multiple vessels and he was deemed a

poor candidate for surgery. Subsequent medical interventions were primarily conservative with a poor prognosis. He was later transferred to a nursing home. Ms EH obviously was very concerned and depressed about the situation. She was devoted and would visit Mr. RH for four to six hours everyday at the nursing home after being driven there by her friends and family. No one could persuade Ms EH to avoid the exertion. She would simply state, "He has always been there for me. Shouldn't I?"

Soon after her husband's admission to the nursing home, Ms EH began to have difficulty keeping up with her appointments with me and the other home health providers. Medicare's guidelines for clients to receive home health under Part-A Insurance Plan require them to meet certain "homebound" criteria. The Center for Medicare and Medicaid Services (CMS), formerly called the Health Care Financing Agency (HCFA), describing homebound status states that, "there exists a normal inability to leave home and, consequently, leaving home would require a considerable and taxing effort. If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment..." (1).

Ethical principles at risk

As per organisational requirements (Medicare's as the regulatory and the home health agency's as the regulated body), Ms EH was clearly homebound based upon her physical limitations; however, her daily absences did not exactly fit the "infrequent" or "short-duration" requirements for Medicare coverage. Much of the ethical confusion was also caused due to the inability of the coverage guideline to exactly quantify the terms "infrequent" and "short duration" and leaving it for further interpretations. The client's expectation and what could be perceived as her right to receive health care at her home based upon her medical necessity (client/consumer rights), and my moral duty to provide treatments and my obligation toward her well-being (my personal beliefs) were thus in conflict with the organisational interpretation/ procedures based on regulations that set criteria for services (rules of practice, possible legal issues involved).

The various ethical principles at risk were as follows:

Autonomy: The client's right based upon her self-determination to receive occupational therapy services at home, and my own professional autonomy to decide where the client should receive the services were under question. As stated by Shanawani and Lowe, our professional schooling prepares us with, "guidelines,

rules and regulations, and legal judgments relevant to our decisions about where to treat patients...(based on) *medical* variables of the patient's health... and the anticipated care needs of the patient. Nowhere do *non-medical* [italics added] variables of patient financial resources, insurance reimbursement, and patient and family preference play an explicit role in those decisions" (2).

Veracity: My professional obligation to speak and act truthfully regarding the client's inability to follow the homebound criteria to continue receiving services at home interfered with my respect for the client's autonomy.

Justice: While I felt a strong sense of duty to care for my client, I realised that the client did not clearly satisfy all Medicare coverage criteria (3).

Fidelity: I viewed this principle as my ability to uphold my commitments to all parties involved, such as the client, my organisation, and the government (via Medicare regulations) and my self as a moral agent.

Benevolence: The client strongly believed that she needed home occupational therapy services and that she was truly benefiting from these. In my professional judgement, too, the client certainly could benefit with continued services. However, this benevolence seemed to conflict with the legal and ethical aspects of delivering services.

Other ethical principles caused me to introspect on what kinds of consequences were good or valuable. I hoped that I was able to be truthful, moral and of benefit to my client through my actions. I also contemplated on what would be a virtuous route to meet the care needs of my client, act in her best interests and cause her maximum gains.

My dilemma forced me to explore the meta-ethical bases of these principles, since several principles were at risk or were conflicting. Do I resolve my ethics based on reason as taught by Immanuel Kant or do I base it on sympathy as proposed by Hume? Do my professional duties conflict with my personal religious beliefs to do good unto others? Will my social contract as a therapist be broken if I discharged my client from my care since she did not meet the Medicare (legal) requirements (4)?

The theories of ethics applicable to my dilemma

My dilemma involved various ethical principles that are based upon different ethical theories. My case, as with most occurrences in health care, had elements of all major ethical theories. The theories influencing my decision process were:

(a) Teleology, in my pursuit to benefit my client (consequentialism); (b) Virtue-based ethics to strive for my client to receive the care and goodness that I or any human may hope for; (c) Value-based ethics to be truthful and good as a person and professional and cause happiness for my client, and (d) Ethics of care due to the therapist-client relationship I had developed and my concern for my client's care. However, I believe that my dilemma and its resolution were derived from and best explained by the theory of deontology.

Deontologism focuses on the very action and its process, and the moral rules and principles involved with the act versus the

consequences of the action itself. It emphasises that one must act in accordance with rules and principles of ethics such as respect for autonomy, non-maleficence, beneficence, justice, fidelity, veracity and avoidance of killing (5). That is, it focuses on acting morally based on one's *duty* versus basing one's action on the *results* that it causes.

The resolution and the methods used

After detailed discussions with the client and her family, I discontinued home-based occupational therapy services and referred the client for outpatient rehabilitation.

Jonsen, Seigler, and Winslade (1998), Purtillo (1993) and Trompetter, Hansen, and Kyler-Hutchinson (1998) have all proposed several methods or processing tools to analyse ethical dilemmas (6,7,8). Kornblau and Starling (1999) also proposed a framework for ethical decision-making. It was called the CELIBATE method (an acronym for 'Clinical Ethics and Legal Issues Bait All Therapists Equally'). The acronym acts as a cue for the user of the framework with each letter representing an aspect for analysis (for example: C for clinical situation, E for ethical issues, L for legal issues, I for information, B for brainstorming action steps, A for analysing action steps, T for taking the action and E for evaluating the results) (5).

In the course of analysing and applying a methodology to resolve my ethical dilemma, I charted my ethical course via a framework. Based on this model, we can divide the entire ethical process when faced by a dilemma into three phases, namely the ethical encounter, the ethical loading and ethical unloading.

The ethical encounter: This phase as applied to my case has been discussed under the section titled 'The case scenario'. The parties involved are the client, my self, the home health agency that employs my services, the CMS, the State Occupational Therapy Board due to its judiciary powers over the practice of occupational therapy, the American Occupational Therapy Association (AOTA) as it regulates the profession and sets codes of ethics (9), the scope (10) and standards of practice (11); the client's family, and the community as a whole based upon the potential impact of my services (or the lack of services) on my client's health and well-being. In the encounter phase, we face all the interacting human and/or organisational components of the ethical issue.

The ethical loading: In this phase we analyse the various issues facing us. Whether the law has been violated, or is at risk, or was there just an ethical problem with no legal implications? My dilemma involves whether or not to continue services although there is a medical necessity, but the client may not necessarily meet the coverage criteria for payment. In this case, one may clearly recognise both ethical and legal issues. Legal issues are based upon Medicare and state practice acts governing the profession as well as the AOTA code of ethics (9) and standards of practice (11). This phase bears the load to introspect and discover legal and ethical violations or risks and analyse methods and the future course of action. We have discussed the ethical issues pertaining to my client in the section titled 'Ethical principles at risk'. In this case, we determined that the theory of deontology best guided our course of resolution.

The ethical unloading: Based upon my realisation and analysis of the ethical-legal aspects involved, I mainly geared my actions toward ethical resolution since there were no legal violations as yet and no separate legal actions were warranted other than those implied by ethical actions. My ethical actions were aimed at mainly upholding deontological principles by following my professional duty as perceived under Medicare and state practice acts, and by not interfering with the regulation with my own interpretation and attempt to liberalise it. I chose to rather use the regulation in its most restrictive form in order to ensure that no confusing elements could cause further dilemmas. This upheld the cause of justice, veracity, and my fidelity toward the law that governs my professional practice.

With the ability to visit her husband at the nursing home at will, the client’s autonomy was upheld as well. Ms EH was also counselled on her options to receive services under Medicare Part-B plan at an outpatient rehabilitation clinic or other qualifying health care facilities. Fortunately, the facility where her spouse was admitted agreed to also treat her as an outpatient. The client found this acceptable and feasible as well.

My course of action also ensured non- malfeasance and beneficence by ensuring continuity of services desired and needed by the client in an environment that was acceptable to her. It is in this phase where I “unloaded” my ethical burden through actions that I chose based upon my prior experience, training and/or conscience.

As with any clinical case, we may view the “ethical encounter” as a phase where we focus on the demographics and situation at hand. The “ethical loading” phase mainly deals with recognising the ethical and legal issues involved (like the diagnostic process), and investigating and selecting the best course of action (formulating a plan for intervention). Finally, the “ethical unloading” phase involves the application of actions/ interventions with the aim of resolving an issue (outcome). Therefore, this phase must also reflect on the effectiveness of the actions/ interventions in meeting the interests of all parties in the situation.

Commentary

In my opinion, this case presents an ethical conflict frequently faced by home health care providers, where they strive to best serve their clients’ needs while navigating through complex financial coverage issues. Emanuel, a physician-philosopher, and Fuchs, an economist, propose the coupling of much-valued freedom of choice with universal health coverage for Americans (12).

The scope of this article was not to address the efficacy of the American health policy but to recognise an everyday dilemma faced in the health care arena. Through experience and common knowledge, we know that health care professionals face similar ethical issues globally. Advances in client education and awareness have led to increased sensitivity and applicability of client rights and autonomy. This has also led to several legal developments and awareness of biomedical-ethics internationally.

A clinician, more than ever before, must be prepared to not only address the clinical needs of his/ her clients but also base this

on socio-cultural and ethical constructs. A sound knowledge of ethical theories and principles helps to guide a clinician’s actions. As Abraham Lincoln once stated, “Let us have faith that right makes might, and in that faith, let us, to the end, dare to do our duty as we understand it (13).”

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Table 1. The ethical process framework

