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IssueBrief

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Do the right thing: Excellence and ethics in case management

Professionals adhere to codes of ethics. For case managers, it's the Code of Professional Conduct for Case Managers. Developed by and for professional case managers, it provides ethical guidelines and principles. It serves as a baseline expectation, regardless of the care setting. Each case manager earning the Certified Case Manager (CCM®) credential must abide by the rules and standards in the Code. (For more on the Code and why it's important, see page 2.)

But don't mistake the Code for a rulebook, says Vivian Campagna, MSN, RN-BC, CCM, chief industry relations officer for the Commission for Case Manager Certification. "Professional case management requires wisdom, judgment and critical thinking."

Campagna, who previously served as the chair of the Commission's Committee on Ethics and Professional Conduct, sees the Code as *informing* professional judgment, not *dictating* behavior. "Case managers reference the Code when an ethical question comes up; its principles can be weighed and applied to any situation."

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About the Code

Originally adopted in 1996, the Commission developed the Code of Professional Conduct for Case Managers to assure quality and protect the public interest. It includes broad principles—advisory in nature—and prescriptive rules and standards for professional conduct. Compliance with the rules and standards in the Code is an expectation for every board-certified case manager (CCM®). Accepted throughout the industry, the Code provides the framework for all case managers to follow. Case managers who carry the CCM credential commit to providing ethical advocacy for their clients, putting the client's safety, privacy and autonomy first.

But why do we even need a Code of Professional Conduct for case managers? That question has several answers, says Vivian Campagna, MSN, RN-BC, CCM, chief industry relations officer for the Commission for Case Manager Certification.

First, it protects the public interest.

"The Code holds clear benefits for the public. It ensures the patient and caregiver are the priority, not cost. It ensures objectivity in making decisions about treatments and procedures," she says. "Importantly, adherence to the Code is a public sign that the case manager is actively engaged in ongoing professional competency—keeping their license and training up to date. And it provides a way for consumers to seek help if needed."

It also supports case managers as they fulfil their primary duty to patients. "Case managers are advocates for clients. That advocacy comes before all other loyalties—sometimes even before the responsibility to an employer. Being able to cite the Code gives case managers the authority to speak out on behalf of their clients—and explain their rationale to employers, payers and other entities."

And finally, it informs their professional judgment, equipping them to grapple with complex ethical questions. It informs who they are as professionals.

Savitri Fedson, MD, MA, associate professor, Center for Medical Ethics and Health Policy, Baylor College of Medicine, agrees with that perspective. "A code of ethics helps establish a common ground, a common lexicon, a set of ideals, but it doesn't help you actually live up to those ideals."

Living up to the ideals

Often, it's not always clear what the ethical response is; she offers the following example:

A 45-year-old woman is admitted after suffering head trauma in a car accident. She has recovered somewhat, but needs extensive physical and speech therapy. Her husband asks about a rehabilitation facility owned by one of his friends. You have had a few interactions with this facility, and patients have not given you good feedback.

You determine that referral to the friend's facility might not be in the patient's best *medical* interest.

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"But what about other interests? Maybe the friend is offering a discount or waiving the copay,

making it more affordable." Family social support, insurance—a whole constellation of issues factor into the decision, Fedson explains.

The same tension applies to other conflicts of interest in which the personal or institutional interests of an individual or of the health care organization will bias perception and action.

The Code calls on case managers to "disclose any conflict of interest to all affected parties, and not take unfair advantage of any professional relationship or exploit others for personal gain."

Again, judgment comes into play. "Not all forms of self-interest are illegal or even unethical," Fedson says. The issue is the failure to identify and manage conflicts that create ethical problems and pose an unacceptable threat.

Of course, if you encounter something that's a likely violation of the Stark law,[1] contact the risk-management department or your supervisor, Fedson says.

The situation may not always be black and white, but she warns against falling into the trap of relativism. "It's *not* all relative," she says. That's particularly true when dealing with medical errors.

Confronting errors

Eventually, almost every case manager will confront a medical error. It's part of being on the care team.

Errors can be complicated, she says. There can be poor outcomes or harm even if everything was done correctly and appropriately, and things can go well even if errors happen. But mistakes—even those that do not cause harm—should generally be disclosed.

"Often, case managers have to disclose errors they didn't make," says Fedson. That can put them is an uncomfortable position. "You want to be able to answer all questions and provide reassurance, but the patient may want to attribute fault to someone, and you are the person standing in front of them."

Disclosure does not mean you—or the hospital—are to blame. The only question is whether the case manager is the right person to disclose the error. Some hospitals use multidisciplinary teams to deal with errors, and risk managers are often lead members of the team.

She is adamant that mistakes *should* be disclosed: Patients still have a right to know. Disclosing errors respects patient autonomy and protects their health. "It also protects health care providers by forcing us to work to continue to improve our practice and to police our own disciplines. This is the core of professionalism."

One common reason for not admitting errors is the fear the disclosure may harm the patient through anxiety, or loss of trust in the medical profession. Fedson doesn't accept that. "I would say they probably lose more trust if they find out through some other means." And they probably will.

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Fedson relayed a story that made headlines last year. A patient sued a prestigious hospital for allegedly removing part of the wrong rib during surgery and then trying to cover up the mistake.[2] The surgical team failed to recognize the wrong rib had been operated on until after the patient had returned to her hospital room. But instead of disclosing the error, they told her they needed to do another procedure. Of course, the truth came out, and the patient sued.

The staff may have been well-intentioned and the facility well-established, but ultimately "fear of admitting the error led to a series of events that increased patient risk,

[1] The Stark law prohibits referrals by physicians for designated health services to an entity or a person with which the physician or immediate family member has a financial relationship. (The law includes some exceptions.) No intent to violate the law is necessary to demonstrate non-compliance.

[2] www.cnn.com/2016/03/23/health/yale-doctor-lawsuit/

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caused patient mistrust of her physicians and ended in litigation," Fedson explains. Perhaps making matters worse, the issue received a lot of play on social media. Patients talk about their cases on social media, she says. "It is easier to get in trouble now than it used to be."

But the real problem with social media isn't patients reporting their negative encounters; it's health care professionals using it unwisely.

Take care with social media

For many in health care, avoiding social media isn't an option. You may be required, for outreach or other purposes, to have a blog, a Facebook profile or some other social media presence.

"If you use social media through work, your profile should reflect you as a health care professional." That requires diligence: You not only need to be concerned about privacy issues, but you will want to be sure everything you post is factual and in keeping with your organization's message.

Another tricky issue for case managers is patients who want to "friend" you. They may not understand the privacy implications when they do so. "They have self-identified themselves as a patient to anyone else who may be your Facebook friend," she says. Use caution when "friending" patients or clients on social media; keep in mind the implicit privacy issue. "You need to understand it because the patient probably doesn't."

As for your personal social media accounts? "The safest strategy is to post *nothing* related to work on personal social media," she says.

Medical societies have been crafting guidance around social media, and there's greater awareness of the risk, she says. Despite all the warnings about being careful on social media, many health care professionals aren't heeding the message. "We've all heard stories of doctors, nurses and other health care professionals being fired after posting information or photos about patients."

Photos and similar confidentiality concerns aren't limited to social media. "We've seen this issue come up a lot at conferences vis-à-vis patient privacy." Sometimes, slides used at medical meetings may have photos of patients or some of their identifying data included. Her advice is the same as it is for social media: "Be discreet."

Moral distress: how to cope

"The responsibilities of what you do as a case manager can be very stressful," Fedson says. As a result, case managers encounter what's called "moral residue" or "moral distress." The cumulative effect of moral distress is dissatisfaction and burnout. "There will be days when you doubt your decision or hate your job." She offers three suggestions for mitigating that stress.

First is to acknowledge that you cannot know and do everything. Simply saying "I don't know" can

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be very powerful, she says. Just be sure to follow it up with an assurance that you'll find an answer—or someone else who can help. "This is a vital phrase, and it's easier when practiced frequently," she says. It actually engenders trust rather than doubt because patients and colleagues know they can believe what you tell them.

The second she calls "the drawer." It can be a drawer, a box or a bulletin board where you keep cards, emails, notes, etc. from patients or colleagues. "Look at them when you are having a bad day, or having a great day. It makes you remember why we do this," Fedson says. And it's a reminder that you do it well.

The third involves developing relationships, especially with those who are more experienced, such as a mentor. But even a peer can fill the role. "Talking through things with colleagues away from the clinical setting can help defuse that anxiety and angst we carry home with us."

Ethics is a process, not a destination

It's important to remember that being an ethical professional is a process, and no one is perfect at it. "Having a lapse of professionalism does not make you a bad person or bad case manager," she says. "You will make mistakes. Your response to making these mistakes and how you try to grow will define you as a 'good' or 'bad' case manager."

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Campagna stresses that being ethical isn't a destination one reaches; it's a process and an evolution. "That's why CCMs are required to have ongoing continuing education in ethics as a part of their renewal process."[3]

But although situations will vary across settings and over time, the fundamentals never change.

"We all know that biotech breakthroughs and information technology are changing the practice of medicine, but some things remain constant," says Campagna. "Characteristics like honor, integrity, objectivity and fidelity never become obsolete. The ethical framework that puts the clients' needs first will endure for board-certified case managers." ■

[3] The requirement went into effect in 2016. For details, see ccmcertification.org/center-stage/ce-update-ethics-related-ce-required-ccm-renewal

About the Experts

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Center for Medical Ethics and Health Policy
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Savitri Fedson, MD, MA, is an associate professor in the Center for Medical Ethics and Health Policy at Baylor College of Medicine and an associate professor in cardiology at the Michael E. DeBakey VA Medical Center. She is a graduate of the MacLean Center for Clinical Medical Ethics Program as a Clinical Fellow at the University of Chicago, where she served as a consulting attending physician for inpatient ethics consultation.

Fedson is an advanced heart failure/transplant cardiologist and, before her move to Texas, worked with the busiest heart transplant center in Illinois. She has been a speaker at national and international heart failure and transplant meetings on topics such as end of life, ethical dilemmas in heart transplant candidacy, and candidacy for mechanical circulatory support.

Vivian Campagna, MSN, RN-BC, CCM
Chief Industry Relations Officer
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Vivian Campagna, MSN, RN-BC, CCM, is the chief industry relations officer (CIRO) for the Commission for Case Manager Certification. She works with individuals and/or organizations that are interested in certification-related products and services. She fosters strategic partnerships and alliances, and provides insight and guidance related to industry trends and developments. She has been involved in case management for more than 20 years, holding staff and administrative positions on both the independent and acute care sides of the industry.

Campagna is a member of the inaugural class of CCMs, a former commissioner and past chair. She earned her nursing diploma from St. Clare's Hospital and Health Center School of Nursing, her bachelor's degree from CW Post Center of Long Island University and her master's degree in nursing from Seton Hall University.

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