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.”
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.

“Often, it’s not always clear what the ethical response is.”
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CENTER FOR MEDICAL ETHICS AND HEALTH POLICY
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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:

"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, 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.

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**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 in 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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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.

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.

“Often, case managers have to disclose errors they didn’t make.”

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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
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.”

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.”

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.”

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