IssueBrief

March 2024

Ethics is messy: How case managers can balance care, advocacy, and self-preservation

Ethics, as Katherine Brown-Saltzman, MA, RN, aptly describes it, is "messy." It's not a formula, nor is it a snap of the fingers. It's intense, often unpredictable, and layered with complexity. Ethical dilemmas are not just about a single issue and are rarely black and white. "If we can start with that premise, it will help us to understand that there is no absolute with a true ethical dilemma. It's about trying to find the best resolution," she explains.

Brown-Saltzman is the co-founder of the UCLA Health Ethics Center. She is also the co-founder and president of Ethics of Caring, a non-profit organization that has provided annual ethics conferences in Southern California since 1994; which has grown into the National Nursing Ethics Conference.

Case managers, as advocates, deal with this complexity every day. They face situations that require them to make difficult decisions that involve multiple stakeholders, including clients, families, health care providers and insurance companies, says Vivian Campagna, DNP, RN, CMGT-BC, CCM, ICE-CCP, chief industry relations officer, Commission for Case Manager Certification.

Ethics is a cornerstone of professional case management practice, and case managers bring their own sense of right and wrong to work daily, she says. But there is rarely one right way to approach a complex situation.

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The CCMC Code of Professional Conduct for Case Managers provides principles for addressing these tough cases, Campagna explains. Case managers set aside their personal feelings,

prioritize the interests of others, respect the rights and dignity of their clients, and follow their lead. Their guiding principle: "Act with integrity and fidelity with clients and others."

And yes, it can get messy.

Relationship-based ethics

Case managers, nurses and those who work alongside them need to understand and implement relationship-based ethics; that requires moving away from a task-focused approach to care. A relationship-based approach emphasizes caring, empathy, and engagement.

This means moving beyond rules and regulations to a moral framework that values oneself as well as others, Brown-Saltzman explains. It's a process, not a checklist. For the sake of efficiency, people often want quick fixes, but ethical dilemmas require hearing all the voices and discerning the best approach. "If we start with that foundation and understand it, we'll be more compassionate and much more willing to engage."

Ethics requires an appreciation of nuance and a willingness to partake in the process. It's not a solitary endeavor; it's a community one.

Too often, nurses and case managers who have been burned by speaking up experience "learned voicelessness," she says. "These are cultures of avoidance, where voices are held at bay to hold up the hierarchal structures." Case managers may feel they face an unsolvable dilemma of serving "two masters."

Building a moral community diverges from this perceived dichotomy.

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Moral community

A moral community, as Brown-Saltzman explains, creates a shared sense of responsibility and obligations. One has different obligations based on their role and professional code of ethics, but we also share common responsibilities.

Clients are seen as a common interest and responsibility. While advocacy, especially for case managers, plays a significant role, it's not just the case manager who acts as an advocate; everyone shares that role. Vulnerable clients need a team advocating for them, not competing to be the best advocate. This collective advocacy, combined with a sense of shared responsibility and obligation, forms the backbone of a moral community.

A process and a conversation

Advocacy isn't about one person taking on the responsibility. It's a collective effort involving the client, family, community, and colleagues. As Brown-Saltzman points out, we all share the responsibility of advocacy. This approach fosters collaboration and reduces antagonism. It's not about one person carrying all of the weight; it's about collaborative advocacy and working together for the client's best interest.

Ethics should be a part of everyday conversation, not held in reserve until a person is pushed to make a choice under extreme circumstances. It's about sharing ideas, raising awareness, educating, and helping people see the full picture. An open space for ethics dialogue is crucial. This includes open communication with clients, families and the community. They should be aware of the resources available and be invited to contribute to the care experience and ways to improve it.

These communities honor disagreement. The question becomes, "How can I look at this other value and not just say, 'That's wrong?' How can I … listen to you and hear why you value this?"

That leads to understanding and respect, even when agreement is elusive. "I may still hold this

value over here, but it means that I can engage with you in a different way. It means that I can work with you, I can honor you," she says.

Collaboration and cohesiveness are key. There should be mutual empowerment among colleagues, encouraging each other to speak up and stand by each other, she says. "It's important to collaborate. It's important how I speak to you with respect."

Leadership and support for ethical considerations should flow both top-down and bottom-up. This is what constitutes a moral community, she emphasizes.

Putting ethics into practice

To move from theory to practice, Brown-Saltzman offers an example drawn from a composite of several real-life cases.

Jennifer is a 21-year-old with a substance use disorder and a complex medical and social history, including homelessness and a background of family drug abuse. After surgery for infective endocarditis, Jennifer faces discharge with a central line for ongoing IV antibiotic treatment, but her substance abuse disorder remains unaddressed. Limited resources and a lack of family support compound the challenges in her case management.

The ethical issues in Jennifer's case include the vulnerability of her situation, the untreated substance use disorder, limited placement options, systemic biases, and the legal aspects of respecting autonomy. Her situation captures the complexity of ethical dilemmas in health care, where no single solution can address all concerns, and the importance of process-oriented, responsive decision-making.

As health care professionals, Brown-Saltzman explains, we grapple with the range of possible responses to these ethical challenges. "Do we voice our concerns, seek workarounds, or call for an ethics consult? Each option can elicit a range of reactions, from support to resistance, within the health care team." The dilemma often lies in balancing the urge to "fix" the situation with the reality of systemic limitations and the need to respect client autonomy.

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Ultimately, Jennifer returned to the ER because the valve failed, though it is not clear why. The surgeon refuses to do further surgery stating it is futile based on her addiction issues, and Jennifer left the hospital against medical advice.

Jennifer's story raises profound questions about the limitations of care and the impact of systemic failures to address individual health challenges. It leaves health care providers grappling with an array of emotions: anger, despair, guilt, and moral distress. This scenario underscores the emotional, physical, and importantly moral toll on health care workers involved in such complex cases.

Moral distress and its residue

"Moral distress occurs when one knows the ethically correct action to take but feels powerless to take that action," says Brown-Saltzman. Moral distress—a term coined by Andrew Jameton in 1984—often arises in ethically complex situations, particularly among case managers and nurses.[1] They experience a sense of powerlessness and voicelessness when constrained from acting according to their moral judgment because of legal issues, institutional policies, or resource limitations.

The consequences of this distress can be severe, leading to disengagement, burnout, and even a

1. Repenshek M. Moral Distress: Inability to Act or Discomfort with Moral Subjectivity? *Nursing Ethics.* 2009;16(6):734-742. doi:https://doi.org/10.1177/0969733009342138.

decrease in the quality of care provided, she warns. Moreover, the impact of moral distress extends beyond the immediate situation, leaving behind a "residue." It never truly disappears, instead accumulating over time with each instance of moral distress.

This accumulation does not make us more resilient; on the contrary, it makes us more susceptible to moral distress, much like a chronic pain patient who never gets a break.

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Moral distress and its residue highlight the importance of reflection as a process to identify these emotions, examine our biases, and understand how we have become habituated in our responses to ethical issues, Brown-Saltzman says.

Through reflection, we can gain clarity and better navigate the challenging landscape of moral distress and moral residue. This understanding can help mitigate the impact of these experiences and improve our ability to provide optimal, ethically sound care.

"Our work is like baking bread; it's transient but meaningful," she says. "It's important to find ways to honor and find meaning in our work."

An opportunity for leadership

This is a critical opportunity for nurse and case manager leaders, who can help prevent moral distress. "Don't wait until these things build up," she counsels. Act preventatively, provide training, intervene early, and give support.

It is essential, she says, to recognize the organization's responsibility to build a healthy workplace environment, while being mindful of wellness.

She emphasizes the importance of creating and integrating ethics into all education and policy development. Above all, an ethical climate gives everyone a voice. "We know that when nurses speak up, moral distress comes down."

Even if the outcome isn't what the nurse hoped for, the fact that they voiced their concern increases empathy and engagement, she says.

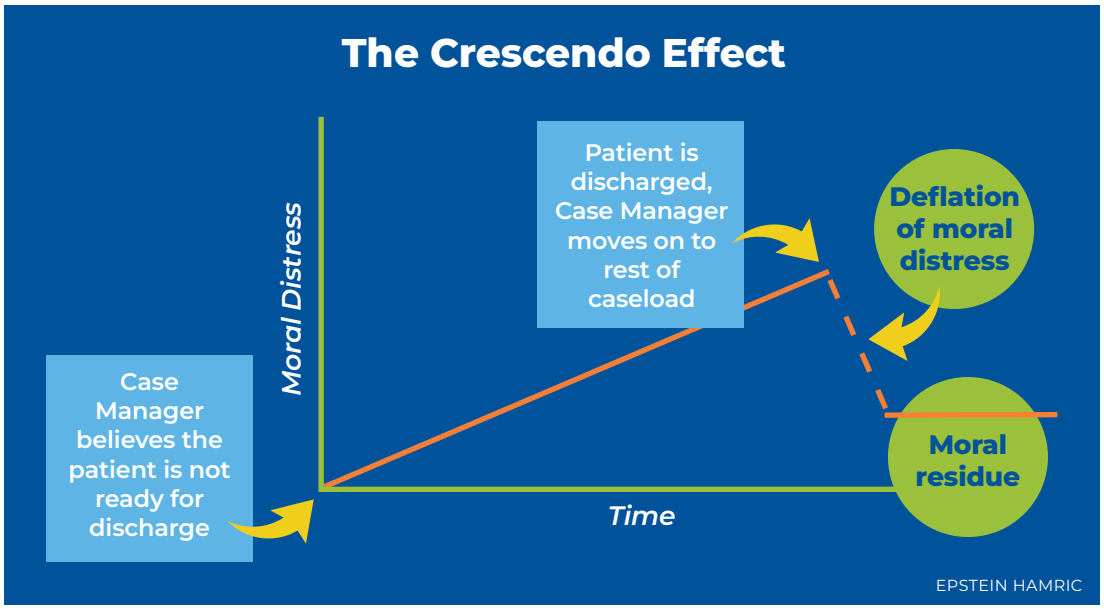

Figure 1

> ***"Do not underestimate self-care as an ethical practice."***
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"If we learn to speak up in effective ways... we can actually remove this voicelessness because we've prepared them through skill-building and practice."

Self-care as an ethical practice

"Do not underestimate self-care as an ethical practice," Campagna says. It benefits individual well-being and enhances one's ability to perform ethically in a health care setting.

Self-care encompasses much more than the oft-touted activities such as eating well, sleeping well, exercising, and meditating, Brown-Saltzman says. "It's about being valued and valuing yourself." It's also about finding meaning and purpose in one's work of caring for others. It involves moral resiliency, and the power of connection and creativity. "Honor your creativity. That can keep us energized and engaged, not responding the same in stagnant ways."

Hope and self-forgiveness are also key elements of self-care. "Even when we are downcast after a difficult situation, thinking, 'My God, what have we done?' We must have hope for the next patient, for the next situation," Brown-Saltzman says. She provides the example of new standards and policies being developed for patients with addiction use disorder, needing multiple valve replacements. "We do not always have the power or knowledge in the moment, but by pursuing the ethical issues we maintain hope and better outcomes over time. And lastly, we must learn to forgive—to forgive ourselves when we haven't been able to resolve a situation as we hoped, to forgive others, to forgive the patient for nonadherence, to forgive that clinician for their bias, but not to tolerate it."

Setting boundaries is a delicate yet crucial aspect of providing care, for the sake of the case

Care Focus of Moral Communities

A moral community means a shared sense of responsibility and obligations. Brown-Saltzman outlines these seven elements that make up a moral community. [2]

- Patients as a common interest/responsibility
- Ethics as normal, everyday conversation
- Open space for ethics dialogue
- Open communication with patients, families, & the community
- Collaboration and cohesiveness
- Mindful interdependence and mutual empowerment
- Leadership support for ethical considerations

Figure 2

> ***"I adopted a new internal mantra: 'I will be with you in this. I will not abandon you. I am not afraid of your pain, and I do not need to internalize it.' This approach allowed me to be a compassionate presence, offering love and support in the moment without taking on the emotional burden myself. It was a metaphorical step back—a way to maintain my own emotional health while still providing the compassion and support my patients needed."***
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2. Pavlish C, Brown-Saltzman K, Jakel P, Fine A. The nature of ethical conflicts and the meaning of moral community in oncology practice. Oncol Nurs Forum. 2014 Mar 1;41(2):130-40. doi: 10.1188/14.ONF.130-140. PMID: 24578073..

manager and for the client. It involves balancing empathy with self-preservation, a skill that often takes time and experience to develop. According to Brown-Saltzman, it comes down to finding the right choreography of engagement. It's about being authentic and present, yet doing so in a way that doesn't lead to self-harm. "It's a dance of caring deeply for others while also caring for oneself, ensuring that we, as health care providers, can continue to offer the best care possible without losing ourselves in the process."

Brown-Saltzman shared her personal experiences with this dance.

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"Early in my career, working in pediatric oncology, I faced immense moral distress. I found myself deeply immersed in the suffering of my patients and their families. Ultimately, I recognized I needed a different approach. It wasn't about erecting an impenetrable wall between me and the patient; such a barrier could erode trust and hinder genuine connection. Instead, it was about finding a way to be empathically present without internalizing the pain of others."

"I adopted a new internal mantra: 'I will be with you in this. I will not abandon you. I am not afraid of your pain, and I do not need to internalize it.' This approach allowed me to be a compassionate presence, offering love and support in the moment without taking on the emotional burden myself. It was a metaphorical step back—a way to maintain my own emotional health while still providing the compassion and support my patients needed."

She realized she needed self-care strategies to survive. For example, playing tennis became an outlet for her anger and frustration. "I also learned the importance of not internalizing patients' pain. It's about being empathic and present without taking on their suffering. This realization was transformative," she says. Spirituality also became a significant aspect of her self-care journey as she developed an awareness of God's presence in her work.

Collaboration, connection, and an ethics of care

"An 'ethics of care' extends far beyond client care to collaborative relationships with health care professionals and the community. It demands a delicate balance between caring for others and self-preservation," Brown-Saltzman says. Advocacy and self-care are both important. So is external support, from institutions and leaders. "Support is vital for a nurse's ability to act ethically and to take action in ethically distressing situations."

The case manager journey is much more than just making the "right" decisions. It is about continually learning and adapting to serve clients while caring for one's self with integrity and compassion. ■

About the Experts

Katherine Brown-Saltzman, MA, RN
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Katherine Brown-Saltzman is the former co-director of the UCLA Health Ethics Center and has made significant contributions to advancing ethical standards in healthcare. She co-founded the UCLA Health Ethics Center, which led to the development of a robust clinical ethics consultation service and a clinical ethics fellowship. Katherine has been active in developing interdisciplinary programs on sustaining self-care, moral distress, and ethics education, including jointly developing a clinical ethics fellowship at UCLA. She is also the co-founder and president of Ethics of Caring, a non-profit organization that has provided annual ethics conferences for Southern California since 1994. She lectures nationally and internationally and has developed ethics and end-of-life care policies. Katherine has published on diverse topics such as ethics, professional self-care, end-of-life care, bereavement, spirituality, psychosocial care, guided imagery, and cultural issues.

Vivian Campagna works with individuals and organizations interested in certification (CCM®/CDMS®), related products and services through the Commission's broader marketing and promotions efforts. She fosters strategic partnerships and alliances and provides insight and guidance related to industry trends and developments. Campagna has been involved in case management for more than twenty-five years. Campagna was a member of the inaugural class of certified case managers and worked with CCMC as a volunteer for more than 10 years. She is a former Commissioner and past chair for the Commission. Campagna 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, her master's degree Seton Hall University, and her Doctorate of Nursing Practice (DNP) from American Sentinel College of Nursing & Health Sciences at Post University. She is certified in case management by both the Commission for Case Manager Certification and the American Nurses Credentialing Corporation.

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