The Ethics of Social Work Practice in a Nursing Home Setting: A Consultants' Dilemma

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This article seeks to contribute to the knowledge base of social work in the area of ethics in nursing home settings. A case example is presented, outlining an ethical dilemma confronting a consultant to a nursing home, to illustrate an ethical reflection process. Literature relating to both sides of the dilemma is reviewed. Ethical perspectives are identified and refined, and ethical theories are employed in the analysis of options. The promotion of an ethics committee in the nursing home is set forth, drawing upon organizational ethics literature.

The Ethics of Social Work Practice in the Nursing Home Setting: A Consultant’s Dilemma Heather Larkin, Ph.D. University at Albany, The State University of New York School of Social Welfare The Journal of Social Work Values and Ethics, Volume 4, Number 3 (2007) © 2007, White Hat Communications This text may be freely shared among individuals, but it may not be republished in any medium without express written consent from the authors and advance notification of White Hat Communications. Key Words: Ethics, nursing homes, older adults, organization, health care, moral philosophy Abstract This article seeks to contribute to the knowledge base of social work in the area of ethics in nursing home settings. A case example is presented, outlining an ethical dilemma confronting a consultant to a nursing home, to illustrate an ethical reflection process. Literature relating to both sides of the dilemma is reviewed. Ethical perspectives are identified and refined, and ethical theories are employed in the analysis of options. The promotion of an ethics committee in the nursing home is set forth, drawing upon organizational ethics literature. 1. Introduction Social workers consulting to, or working in, nursing homes deal with complex situations and confront challenging ethical dilemmas. Yet, there is minimal literature regarding the ways that ethical choices are influenced by social workers in health care settings (Conrad, 1982; Joseph & Conrad, 1989; Ross, 1992). This is in spite of the fact that medical developments prolonging life have made health care decision-making more complex (Beauchamp & Childress, 2001; Galambos, 1998; Kaufman, 2004). Furthermore, conflicting expectations of the organization; medical staff; and patient family members must be balanced with the needs of the patient, leading to the potential for ethical dilemmas (Beauchamp & Childress, 2001; Conrad, 1982; Cummings & Cockerham, 1997; Reamer, 1990). Galambos (1998) points out that ethical dilemmas are commonly associated with end-of-life treatment decision-making and emphasizes the importance of policy and practice supportive of client autonomy. According to Schwiebert, Myers, and Dice (2000), clinicians need to be able to utilize ethical models to be able to make suitable ethical decisions in service to older adults. The need for social workers to competently navigate ethical issues in nursing homes becomes even more critical in light of frequent nursing home abuses. According to a U.S. House of Representatives (2001) report, nine thousand abuse violations were reported in more than 30% of United States nursing homes between January 1999 and January 2001. There was actual harm to residents, placing them at risk of serious injury or death, in 10% of the facilities. While some of the reports resulted from physical or sexual abuse of residents by a staff person, there were also cases in which a nursing home was reported because it did not shield defenseless residents from other abusive residents (U.S. House of Representatives, 2001). This article seeks to contribute to the understanding of ethical decision-making processes in nursing home settings through the analysis of a case situation in which the resident presents with non-compliant behavior that can affect his well-being and that of other residents, as well as issues related to the moral responsibility of the social worker. Closely related are ethical concerns regarding the responsibility of the organization to the other residents or, in ethical terms, responsibility for the common good. Joseph’s (1985) model for ethical problem-solving is used to illustrate an ethical reflection process that has been helpful in resolving complex moral dilemmas in various health and social service settings. The essential components of Joseph’s (1985) model involve the following steps: presentation of the case, clarification of the ethical dilemma involved in the case, provision of relevant background information, identification of the moral values and ethical principles involved in the dilemma, the application of ethical theory, outline of ethical options, and the position of the author. It is hoped that through the use of such ethical tools, skill in ethical decision-making will be enhanced, which in turn will contribute to practice excellence in nursing home settings. Whereas the focus of this article is from the perspective of the social work consultant to a nursing home host setting, this example is likely to be helpful to social workers in various other host settings, as well. This furthers the application of Joseph’s (1985) decision-making model at a time when social workers are increasingly called to work collaboratively across systems. This article begins with the case presentation, following the steps outlined in Joseph’s (1985) model. 2. Practice Situation and the Related Ethical Issues 2.1. Case Example Mr. X is an older cognitively impaired man with some history of alcohol abuse who is now a resident of the nursing home. He enjoys smoking cigarettes in a designated smoking room but is not involved in any other activities. The nurses are concerned, because he has been yelling at other residents, and when someone is in his way, he pushes them. It seems that he immediately reacts to his frustration. When someone talks to him about what he has done, he becomes defensive. When it is explained to him that he cannot do things that way, he becomes tearful and says that he is sorry. Because of staff shortages, the nursing home has been unable to follow through with psychosocial recommendations. Two months after the initial social work consultation, the nursing home calls the social worker to say that they want Mr. X psychiatrically hospitalized on an emergency basis. It seems that his behavior has continued, and this is a particularly stressful day for the staff: Mr. X’s usual Certified Nurse Assistant (CNA) is out sick, and several other residents have been acting out today, as well. The resident is very remorseful and tearful but is otherwise calm at this point. He is concerned that “they will send me away,” and he makes it very clear that he does not want to go anywhere. When asked what he would do instead of yell or push if someone were to bother him again, he says that he would “walk away.” The nursing home staff members continue to insist that they want Mr. X psychiatrically

hospitalized immediately and are not interested in attempting any interventions within the nursing home setting at this point. 2.2. The Ethical Dilemma Good practice skill and technical practice knowledge are very important to obviate an ethical issue (Conrad & Joseph, 1991; Joseph, 1985), and it is tempting to explore the details of this case and the surrounding practice issues further. The purpose of this analysis, however, is to raise the issue to an ethical level rather than prioritizing around practice interventions. “The technical aspects of practice are oriented to the effective accomplishment of the tasks of assessment, intervention, termination, and evaluation or the measurable outcome of an intervention, whereas the ethical aspects of practice are oriented to helping in accord with moral standards of professional conduct” (Conrad & Joseph, 1991, p. 6). Joseph (1985) points out that ethical skills add to decision-making ability and client service. The central dilemma of this case is responsibility to the client vs. responsibility to the employing agency in a host setting, which involves concerns for both autonomy and community. 3. Relevant Background Information The conduct of social workers is guided by the values, principles, and standards embodied in the NASW Code of Ethics (1999), which states that the core of social work is its professional ethics. This Code indicates that the well-being of clients is the primary responsibility of the social worker. The respect and promotion of the right of clients to self-determination is also among social workers’ ethical responsibilities to clients. At the same time, the Code also states that commitments made to employing agencies should generally be adhered to by social workers. An ethical dilemma entails two competing goods (Conrad, 1988; Cummings & Cockerham, 1997; Golden & Sonneborn, 1998; Joseph, 1985; Reamer, 1990; Schweibert et al, 2000), in this case fiduciary responsibility to the client vs. fiduciary responsibility to the employing host setting, also a client system. Thus, the consulting social worker is confronted with a question in terms of action in regard to obligations, norms, and personal or professional values (Conrad, 1988). The NASW Code of Ethics (1999) itself points out that it is not ordering its values, principles, and standards, suggesting that social workers give consideration to all that pertain to the situation in which there is a conflict. 3.1. Responsibility to the Client Galambos (1999) points out that the NASW Code of Ethics (1999) indicates that other responsibilities should come after the commitment to well-being of clients. Furthermore, the NASW Code of Ethics (1999) states that social workers need to educate employers about ethical issues and their impact upon practice. Galambos (1999) also suggests that at the start of employment, social workers discuss the importance of making choices to protect the best interest of the client, superseding the concern of the employer. Elderly people are among those vulnerable groups who are further disadvantaged by systems that focus on the financial interests of an organization and efficiency rather than client needs. Galambos (1999) further points out that social workers are obliged to pursue social change for populations who are oppressed or vulnerable. Reinardy and Kane (1999) found that nursing home residents had experienced moves without being involved in the decision-making process and suggest that social workers be sensitive to the value of facilitation of the older person’s experience of choice, which can affect his or her sense of well-being. Galambos (1997) explains that the quality of life of older people is related to their sense of emotional, physical, and spiritual well-being and draws upon the ethical principles of autonomy and beneficence and standards set forth by the White House Conference on Aging to promote this well-being. Policies should support independence, privacy, and self-control while offering protection, advocacy, and humane treatment for older people (Galambos, 1997). The findings of Kruzich and Powell (1995) indicate that the autonomy of nursing home residents can be increased by the important role social workers play in empowering residents. Berger and Majerovitz (1998) advise that even elderly people experiencing mild dementia should not be excluded from health care decisions, finding that they were still able to make treatment choices in keeping with their previous decisions. Furthermore, there is a question about whether the attempt to achieve physical safety for an older client may actually cause harm by taking away his or her freedom (Kane & Levin, 1998). Also, it is just as important to consider the threat of harm to the person being restrained as it is to diminish harm to other residents (Dodds, 1996; Mion, 1993). Salladay (1998) insists that just because something may be more efficient for staff, this does not mean that the dignity or rights of the nursing home resident should be compromised. In a similar vein, Hartigan (1997) suggests that the tight budgets of nursing homes should not concede appropriate care. It is ethical to individualize approaches and train staff to respond proactively rather than reactively to residents with difficult behaviors (Stanford, 1995). 3.2 Responsibility to the Employing Agency On the other hand, the NASW Code of Ethics (1999) does indicate that loyalty to clients may be overridden by a responsibility to the larger society and that the client’s right to self-determination can be limited when it is clear that the client’s actions present a significant risk of harm. Additionally, social workers are expected to maintain a commitment to employers (Reamer, 1990). A duty to the community can be at odds with the responsibility to advocate for the individual patient (Parsi, 1999), and the nursing home itself is a client system. Ethical issues also need to be considered from the care provider’s point of view, highlighting the autonomy of the front-line caregivers at the nursing home. According to Stone and Yamada (1998), caregivers need to be empowered for the residents they care for to be empowered. It is these front-line workers who are potential recipients of belligerent behavior, and Stone and Yamada (1998) focus on the enhancement of autonomy for all members of the nursing home community. Finally, the concept of social autonomy has been presented as an alternative to the liberal view of autonomy that attempts to separate the personal and social spheres and focuses on non-interference with the individual (Proot, 1998). An alternative view is one that recognizes dependence as part of the human condition and understands the role social context plays in human development. Thus, one’s current environment and developmental capacity provide the context for their degree of actual autonomy (Agich, 1993; Proot, 1998) 3.3 Legal Issues and Abuses The next step in Joseph’s (1985) ethical decision-making model includes the consideration of legal issues relevant to the dilemma. The Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) included legislation reforming nursing homes. Nursing homes that took part in Medicare and Medicaid programs began to be required to meet specific standards of quality care. Two of the care requirements are particularly relevant to the case presented in this article: “Have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial [emphasis added] well-being of each resident, as determined

by resident assessments and individual plans of care (42CFR 483.30)” and “Develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident’s medical, nursing, and mental and psychosocial [emphasis added] needs that are developed in the comprehensive assessment. The care plan must be developed within 7 days after completion of the comprehensive assessment and describe the services that are to be furnished. Also, the care plan must be periodically reviewed and revised by a team of qualified [emphasis added] persons after each assessment (42 CFR 483.20)” (Federal and State Laws Regulating Nursing homes). These regulations are not being adequately met by the nursing home involved in the case presented in this article. In fact, a study of psychosocial services in skilled nursing facilities conducted by the office of the inspector general found that 39% of Medicare recipients in skilled nursing facilities did not have all of their psychosocial needs addressed in care plans and 46% did not obtain all of the psychosocial services outlined in their care plans (Rehnquist, 2003). This is in keeping with O’Neill’s (2002) finding that psychosocial service delivery is not enforced and is essentially considered voluntary for nursing home owners. For-profit nursing homes are especially likely to provide limited services, defying federal regulations. Psychosocial needs and the importance of social work are not understood by many administrators. At the same time, there have been cutbacks in compensation from Medicare and Medicaid, and nursing home administrators are concerned about costs. Since the government does not monitor the credentials of those hired for social work positions in nursing homes, there is a situation in which untrained people are hired and assigned inappropriate tasks (O’Neill, 2002). There is clearly a need for social work research to present the long-term costs of the current situation. It will also be necessary for the profession to provide education around the important roles that professionally trained social workers can play to improve the care provided to elderly persons in nursing home settings, saving society money and heartache over time. 4. Values and Preferences

4.1. Value Judgment

The literature highlights the tension between the person and collective environment, bringing forth compelling concerns for both client autonomy and community well-being, which compete for our attention. It is also clear that the professional Code of Ethics (1999) is limited in managing these value conflicts, leading to the use of philosophical ethics by social workers (Conrad, 1988; Joseph, 1985). Values are an important part of moral philosophy, and it is out of our values that flow principles and standard rules. The ethical model of decision-making presented by Joseph (1985) seeks to bring value conflicts to the surface in order to promote self-awareness and lead to the utilization of ethical principles in practice. Because the resolution of ethical dilemmas can be subtly influenced by the values of social workers, consciousness of these values assists the social worker in recognizing the impact upon the decision-making process (Frankena, 1973; Mattison, 2000). Values apparent in the dilemma presented in this article include autonomy, respect, importance of relationships, trust, service, and community. In attempting to develop a hierarchy of values pertinent to the ethical dilemma being explored, autonomy seems to come first. Autonomy would encapsulate all of the other values – why would any of them be important if there was not first a value of freedom to run one’s own life? Next would come community, as someone needs a community in which to practice autonomy, which develops in a community context. Relationships would be non-existent without community. The need for respect comes into play once there are relationships. Service may not be needed if there are no problems related to the previous values, and trust is what is expected from service. In this way, the following values hierarchy is presented in this article: Autonomy, community, relationships, respect, service, trust. Figure 1 Values Hierarchy Autonomy Community Relationships Respect Service Trust In clarifying the values hierarchy, which includes both autonomy and community, it becomes clear that client freedom vs. well-being of community is involved in the focal dilemma of responsibility to the client vs. responsibility to the employing agency. Principles grow out of values and can be considered general guides, which continue to provide space for reasoning (Beauchamp & Childress, 2001). The principle that would flow from autonomy would be that the client should be free to make choices about important life decisions. The principle of beneficence, or “doing good,” would flow from the value of freedom from harm, related to the autonomy of other residents (Beauchamp & Childress, 2001; Schwiebert et al, 2000). These principles can be in conflict, and it becomes difficult when there is disagreement among parties as to what constitutes a harm or a benefit (Beauchamp & Childress, 2001; Cummings & Cockerham, 1997; Schwiebert et al, 2000). In valuing the autonomy of the whole community, both freedom of choice and freedom from harm, would flow the principle of challenging social injustice. 5. Ethical Decision-Making Courses of action could flow from either side of the dilemma – advocate for the client’s autonomy or follow through with a commitment to the employer and concern for other residents and staff. One could also appeal to regulations in an attempt to influence the nursing home to be able to carry out recommendations within that setting. Practice skill could be used to explain what is or is not an appropriate intervention for certain diagnoses. Finally, the situation could be brought to an ethical level and discussed with key players involved with the situation in an attempt to address the needs of both the resident and the nursing home community as a whole. This last option would be the point at which ethical knowledge and practice skill interact, with ethical skills adding to decision-making and client service (Joseph, 1985). This article presents this last option as most completely maximizing the identified values, advocating for the development of an ethics committee in the nursing home setting. An ethics committee offers a procedure for resolving dilemmas such as the one presented in this article. This committee would be made up of social workers, physicians, nurses, patients, family members and others who would reflect upon the ethical dilemma and provide consultation. In this way, the ethics committee also contributes to the moral responsibility of the organization, promoting an ethical culture (Conrad, 1990; see also the Maryland Healthcare Ethics Committee Network as one example: http://www.law.umaryland.edu/specialty/mhecn/index.asp). By involving the nursing home in ethical considerations, this is valuing the autonomy of all staff persons as well as the resident

community. Furthermore, staff persons are more likely to hold a sense of ownership regarding the choice that is made in this situation. Steffen, Nystrom, & O’Connor (1996) found that results for residents and outlooks regarding the work were improved by involving nursing home staff members in decision-making. Rather than choosing between the resident and the nursing home, this is an opportunity to facilitate the development of an ethical decision-making team within the organization that would be in support of its provision of quality services to residents. This includes the nursing home staff in the reflection process in place of going over their heads to report regulatory violations. Through this involvement, the nursing home staff may begin to see the point of regulations or advocate for themselves to gain funding to meet requirements (NASW, 1998, Case 77, p.91). Practice skill can facilitate the ethical decision-making dialogue among the key participants. This is in keeping with the arguments of some that organizations do have moral responsibility. They are made up of persons and carry out the rights and responsibilities of persons. People with an intrinsic morality are the ones fulfilling the work of the organization (Hyatt, 2000; Joseph, 1983). Furthermore, human service agencies are recognized as being moral agents, because they serve human needs and vulnerable populations and profess this to the public. There is tension in the case of the for-profit organization that has the goal of efficiency to make a profit for shareholders. Yet, there is also the need to provide quality service, so even the for-profit human service organization has values other than efficiency (Bonn, 1996; Fahey & Vito, 1996; Hyatt, 2000; Joseph, 1983). It would be recognition of the need to provide quality service that would dispose the organization to value autonomy of residents and community. Joseph (1989) has called for increased consideration to the moral responsibility of human service organizations. It has been suggested that an ethics committee is important to have in an agency and can assist in the development of decision-making guidelines (Conrad, 1990; Curtin, 1994; Hyatt, 1994). 5.1 Ethical Theories Finally, Joseph’s (1985) model draws upon ethical theories, examining their support for various courses of action. Beauchamp and Childress (2001) recognize that it is tempting to choose a theory among competing theories but suggest that this is risky in ethics. They speak to the convergence across theories, recognizing that different standpoints can still support similar principles, virtues, responsibilities, rights, and obligations. For practical purposes, the differences may not actually be that major. Furthermore, theories have strengths and weaknesses in different areas, and there can be recognition of the helpful aspects in the various theories without having to make a choice among them (Beauchamp & Childress, 2001). For this reason, this article will briefly describe deontological, utilitarian, and teleological theories; suggesting that social workers integrate use of all of the theories in order to be able to facilitate discussions by ethical teams and clarify perspectives that might be presented. Deontological theory focuses on the act or rule itself, regardless of consequences, suggesting that what is morally right is not always the greater good. Kant emphasized the autonomous will and said that people are ends in themselves and cannot be used as means (Frankena, 1973). A deontologist might explain that the principle that one should be free to make choices about important life decisions is more important than the possible costs to the nursing home community. This theory would maximize the value of autonomy, considered to be a primary value in the previously developed hierarchy. It is also possible, however, that one might use this theory to focus on the autonomy of the other residents, suggesting that their right to be free from harm so they can make their own life choices is primary. Utilitarian theory is an ethical theory fashioned by Bentham, who believed that a decision should be considered ethical when it led to the greatest good for the greatest number of people. The principle of utility is the concern in this theory, and the emphasis is solely on the consequences. Bentham was actually making attempts to calculate pains and pleasures associated with decisions (Frankena, 1973). A utilitarian theorist might suggest that temporarily removing Mr. X from the nursing home setting would serve the greater good. A critique of utilitarianism is that it ignores the minority; in this case, Mr. X’s wishes would be disregarded. John Stuart Mill is a utilitarian theorist who put more stress on altruism in the cost-benefit analysis (Frankena, 1973). For example, the primary value of autonomy and the second value of community in the hierarchy could be used to define the good. If autonomy for the whole community is considered to be a greater good than the cost-savings to the nursing home, then the nursing home could be asked to take responsibility to find ways to hire more staff to protect the autonomy of everyone, including Mr. X. Furthermore, research indicating the long-term costs of psychiatric care for residents in comparison to the costs of ongoing appropriate psychosocial services in the nursing home might demonstrate that it is much more useful for the nursing home to hire appropriate staff to carry out recommendations for Mr. X and protect other residents than to send Mr. X and others like him to psychiatric hospitals when crises erupt. Thomas Aquinas based his philosophy on Aristotle, developing the ethical system of teleology. Teleology considers the intention, the action itself, the circumstances, and the end result of the action and is concerned with the amount of good that is produced. If an action is likely to or intends to produce “at least as great a balance of good over evil” as any of the other possible outcomes, then it is right and is an action that should be carried out (Frankena, 1973). Drawing on the primary value in the hierarchy, a teleologist might suggest that the most good is likely to be produced by first valuing the autonomy of the staff as community members, expecting them to make responsible ethical choices. Once their own autonomy is valued, are they likely to discount the autonomy of other community members? When the nursing home chooses to value the autonomy of its community members, what might they begin to advocate for on their own? Once the nursing home staff members themselves begin to fully recognize their circumstances in society and become conscious of their intentions and possible end results of their actions, what will they be likely to do? Will they want to defy nursing home regulations? Could this be the start of an ethics committee in this organization? How much good will then be produced over time if the organization itself commits to ongoing ethical considerations? 6. Conclusion When the ethical decision making model was applied to the case of an individual nursing home resident, a larger concern related to organizational moral responsibility emerged. The social work profession’s person-in-environment perspective aids in both recognizing and working with this interplay (Larkin, 2005). The chosen ethical option involved engaging the nursing home community in the decision-making itself, developing an ethics team. Such a team would use models such as the one presented in this case analysis to offer consultation through a process of ethical reflection and determination. The expectation is that

this would support the nursing home in advocating for itself to be able to meet requirements that would be supportive of maintaining the safety of Mr. X and others in the nursing home community. The concerns brought forth in this article are likely to be shared by social workers in other host settings, such as schools and correctional facilities. In fact, it appears that a social worker cannot avoid dealing with ethical issues in organizations (Conrad, 1982; Conrad, 1990; Hyatt, 1994; Joseph, 1983; Joseph & Conrad, 1989). Not only are social workers employed by agencies, but they are called upon to consult around dilemmas and may be members of ethical teams (Conrad, 1990). More and more, social work practice is being influenced by large organizations, and there are times when the forces of the organization feel beyond the control of the individual social worker (Rhodes, 1989). Professionals working in bureaucratic organizations may experience a feeling of alienation between their own morality and their organization and colleagues, seeing their moral duty and their duty to the organization as separate (Manning, 1997). Burnout can be related to an underlying ethical issue in the organization, as well (Conrad, 1990; Poulin & Walter, 1993). Thus, social workers in all settings need to become familiar with ethical decision-making models pertaining to organizational ethics in order to make choices within these structures (Joseph, 1983). Furthermore, it seems critical that social workers consulting to nursing homes and other host settings promote the development of an ethics committee, encouraging ownership of choices by the organization and fostering a sense of a moral community. Whereas ethics committees are still a recent addition to nursing homes (and do not yet exist in many other social work host settings), they are important, because decisions involved in these settings are particularly complex, and the committee can assist in the development of procedures to work through cases such as the one presented (Conrad, 1982; Conrad, 1990; Hyatt, 1994; Joseph & Conrad, 1989). Relationships, respect, service, and trust would flow out of this arrangement, and social injustice could be challenged. Social workers can combine ethical knowledge with practice skill to facilitate effective deliberation by the nursing home community (Conrad & Joseph, 1991; Joseph, 1985). At the same time, social work research is necessary to provide realistic information to nursing homes and society as a whole about the outcomes of various courses of action. It is critical that society both enforce nursing home regulations and support nursing homes in carrying out their services to vulnerable older persons. Nursing homes may benefit from hiring professionally trained social workers, appropriately utilizing their skills, and developing ethics committees. References Agich, G. J. (1993). Autonomy and long-term care. Oxford: Oxford University Press. Beauchamp, T.L. & Childress, J. F. (2001). Principles of biomedical ethics (5th ed.). New York, NY: Oxford University Press. Berger, J. T., & Majerovitz, D. (1998). Stability of preferences for treatment among nursing home residents. The Gerontologist, 38(2), 217-223. Bonn, K. L. (1996). Speak up! Nursing Homes, 45(4), 64-66. Conrad, A. P. (1982). The health care policy pendulum: an ethical perspective. Social Thought, 8(1), 25-38. Conrad, A. P. (1988). Ethical considerations in the psychosocial process. The Journal of Contemporary Social Work, 69(10), 603-610. Conrad, A. P. (1990). Developing an ethics review process in a social service agency. Social Thought, 15(3/4), 102-115. Conrad, A. P., & Joseph, M. V. (1991). Ethical problem solving skills in social work practice. Social Thought, 17(3), 5-15. Cummings, S. M., & Cockerham, C. (1997). Ethical dilemmas in discharge planning for patients with Alzheimer’s disease. Health and Social Work, 22(2), 101-108. Curtin, L. L. (1994). Ethical concerns of nutritional life support. Nursing Management, 25(1),14-19. Dodds, S. (1996). Exercising restraint: Autonomy, welfare, and elderly patients. Journal of Medical Ethics, 22(3),160-167. Fahey, C. J., & Vito, G. (1996). The ethics of managed care. Nursing Homes, 45(5), 27-31. . Frankena, W. (1973). Ethics (2nd ed.). Englewood Cliffs, NJ: Prentice Hall Publishers. Galambos, C. (1997). Quality of life for the elder: A reality of an illusion? Journal of Gerontological Social Work, 27(3), 27-44. Galambos, C. (1998). Preserving end-of-life autonomy: The patient self-determination act and the uniform health care decisions act. Health & Social Work, 23(4), 275-281. Galambos, C. (1999). Resolving ethical conflicts in a managed health care environment. Health and Social Work, 24(3), 191-197. Golden, R. L., & Sonneborn, G. S. (1998). Ethics in clinical practice with older adults: Recognizing biases and respecting boundaries. Generations, 09/22/88, 82-87.

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