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Special Issue on Ethics in Geriatric Care Management

Message from the Guest Editor <i>Connie Rosenberg, MPS, RN, CCM, CMC</i>	2
Translating Ethics to End of Life Care Management <i>Kathy Kinlaw, M.Div.</i>	3
Ethics in the Business of Geriatric Care Management <i>Phyllis Mensh Brostoff, CISW, CMC</i>	6
Strategies for Resolving Ethical Issues in Geriatric Care Management <i>Ray Moseley, Ph.D., and Rona Bartelstone, LCSW, BCD, CMC</i>	10
Geriatric Fiblets - Necessary White Lies or Bad Therapeutic Technique? How to do an ethical query for your own practice <i>Cathy Jo Cress, MSW, and Michele Boudinot, MA</i>	14

GUEST EDITOR'S MESSAGE

Message from the Guest Editor

Connie Rosenberg, MPS, RN, CCM, CMC

The Standards of Practice of GCM have long been dear to my heart! I was so pleased when asked to be the Guest Editor for this issue. I chaired the Standards Committee back in the late 1980s when we worked on the first Code of Ethics and Standards of Practice for care managers in private practice. At that time all members were business owners in private practice. Since that time, I have been on the Committee almost continuously and have chaired the Committee again from 2003 until 2005. Many of the original Committee members continue to be actively involved in our organization and others continue on the Standards Committee today. The Standards and Code of Ethics were first approved in 1990 and changes have been made to the Standards as the need arose.

The existence of our Standards and Code of Ethics gives GCM members a guide to use when dealing with both clinical care management issues and business issues that we face in running our practices. These standards are a moral compass to use when facing some of our toughest decisions. In addition to using these Standards as a guide, it is extremely helpful to discuss the ethical dilemmas we face with fellow care managers. This is a simple task if one works in an agency with multiple care managers. However, many of our members are sole proprietors and need to be creative in finding ways to brainstorm about a particularly difficult issue. One idea is to telephone a colleague with whom you have a relationship in which you can openly discuss your dilemmas. This is something that I myself have done at times. Another option is to form networking groups within a GCM

Chapter which can be used to share case studies and discuss ethical issues. In recent years the GCM list serve has been another useful tool used by members.

All of the authors in this issue of the Journal have provided us with thought provoking material. Phyllis Brostoff, CISW, CMC, who drafted the original outline for the GCM Standards of Practice, has addressed business issues. Cathy Cress, MSW, who wrote the first textbook on the topic of geriatric care management, including an excellent chapter on ethics, has written, together with Michele Boudinot, MA, an article on "Geriatric Fiblets" that will have us all reflecting on how we communicate

with persons with dementia. Rona Bartelstone, MSW, LCSW, Past President of GCM, together with Ray Mosely, PhD, has provided us with strategies for resolving the ethical issues we confront on a daily basis. Kathy Kinlaw, M.Div, Acting Director of the Center for Ethics at Emory University, has provided us with "tools" to address End of Life issues.

I hope you all enjoy this issue on ethics as much as I do!

Connie Rosenberg MPS, RN, CCM, CMC, is president of Services and Resources for Seniors, Inc., in Morristown, NJ.



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Translating Ethics to End of Life Care Management

Kathy Kinlaw, M.Div.

Over the last two decades many advances have been made in dealing with life-threatening illness. Research and technology have given hope of potential curative measures, and life-prolonging treatments have added years for individuals dealing with many illnesses such as end-stage chronic illnesses and many cancers. These advances have also led to high expectations from patients and families as well as health care professionals that therapies exist or can be discovered to overcome life-threatening illness.

Relational Goal Setting

As GCM's work with these patients and their families, a significant contribution can be made by helping all involved discuss realistic goals. A GCM's challenge in working with patients with life-threatening illness is to begin to establish a relationship which provides a firm basis for respectful, caring communication. This communication involves listening with integrity, helping the patient determine whose voices need to be "at the table," maintaining some element of

hope, and assuring the GCM's presence throughout; each component is essential to goal setting and patient respect. This basis provides the foundation for approaching fears and hopes and re-assessing patient goals throughout the medical course.

Many health care professionals - just as many individuals in our society at large - are simply reluctant to talk about death. And this may be precisely what the patient most wants to gently approach, but feels that he/she must protect his/her family from these concerns...

the patient. Many health care professionals - just as many individuals in our society at large - are simply reluctant to talk about death. And this may be precisely what the patient most wants to gently approach, but feels that he/she must protect his/her family from these concerns or that he/she is betraying the physician who continues to talk about interventions and potential cures. Some individuals may also hold cultural or belief-based

concerns that talking about death may actually anticipate or bring death on. Yet, willingness to talk about death and active comfort care along with the possible disease interventions often "demythologizes" patients' fears in ways that may be very empowering for patients and families.

And the U.S. public at large is actually beginning to talk more about end-of-life preferences. During November 9 to 27, 2005, 1500 adults in the continental U.S. participated in the Pew Research Center's telephone survey on End of Life Treatment. (Kohut et al, 2006). Sixty-nine percent (69 %) of married respondents had had a conversation with their spouse about his or her wishes for medical treatment in medical circumstances with no hope of improvement. This percentage was significantly increased from 51% in 1990.

The Language of Ethics

Ethical language can be very helpful in talking with patients about their fears and end of life care preferences. Seeing ethics as a resource quickly moves one beyond what is "right" or "wrong," to helping patients understand how they think about decision making about their own care.

1. What are the patient's sources of "moral authority?" Do the patient's values/beliefs draw heavily on religious, family, cultural or other sources? What does the patient interpret those authorities to "require" of them at this point of illness? Are there religious leaders or others who can help interpret these authorities?

(continued on page 4)

Translating Ethics to End of Life Care Management

(continued from page 3)

2. Can the patient imagine a point at which he/she would not want to go through further medical intervention? How would the patient describe that point? For example:
 - a. Is likelihood of success of treatment or degree of benefit important?
 - b. Would there be a point at which enduring pain or other symptoms would make continuing intervention less desirable?
 - c. Is the anticipated quality of life reasonable to the patient?
 - d. If the chance of success of a procedure was reasonable for a patient, but would involve significant long-term side effects or would keep the patient away from family/friends, would the patient be willing to undergo this therapy?

These questions begin to help the patient determine what would be in his/her best interests and what harm would simply be too much.

3. How influential are the anticipated consequences of the action to the patient as they consider what decision to make? The theory or approach called "teleology" or "consequentialism" acknowledges that many individuals look carefully at the goals or consequences expected in a health care decision and choose that option that is expected to yield the desired end or the best outcome. For other patients or health care professionals there may be

certain duties or values that the individual believes must be upheld in a decision, regardless of the consequences of the choice. Understanding when patients or colleagues are utilizing this approach, referred to in the ethics literature as "deontology," may help the GMC facilitate decision making, especially when different family members or health team members are approaching the decision using different ethical approaches.

Are patients and family members willing to talk about choices to limit treatment at the end of life? The Pew study indicates that 84% of respondents approved of laws that would allow a terminally ill patient to decide whether to be kept alive through medical treatment.

4. Are there relationships so important to the patient, that the impact of the decision on that person(s) would influence what the patient might decide? For example, is the patient concerned that it will be too difficult on the spouse to continue caring for the patient? Is the patient willing to agree to another round of chemotherapy because a family member or friend is not ready to "let go" of the patient? Is the patient concerned about using up financial reserves that the spouse might need or that the patient hoped to pass on to grandchildren?

Treatment Decisions and Advance Care Planning

Are patients and family members willing to talk about choices to limit treatment at the end of life? The Pew study indicates that 84% of respondents approved of laws that would allow a terminally ill patient to decide whether to be kept alive through medical treatment. Seventy percent (70%) of respondents indicated that

sometimes there are circumstance in which patients should be allowed to die rather than everything possible being done by physicians and nurses to try and save the patient's life. (Kohut et al, 2006)

And more individuals are taking part in "advance care planning" - considering what their medical preferences would be should they no longer be able to speak for themselves, and then communicating to other decision makers what medical treatment they would want at that point. Twenty-seven (27%) of all

respondents in the Pew study had written down their wishes for medical treatment (as opposed to 12% in 1990); 29% indicated that they had a "living will," as compared with only 12% of respondents in 1990. There are still important

questions about advance directives, the legal documents (usually including the living will and the durable power of attorney for health care) that provide written evidence of what a patient's treatment preferences are when the patient is no longer able to express them. Most living wills do not provide information in enough detail to direct treatment decisions in specific situations. For example, the Georgia living will category "in a coma with no reasonable expectation of regaining consciousness" may be difficult to clinically determine. Many advance directives also do not indicate clearly what interventions should be withheld, by what process or how quickly these decisions should be made. The durable power of attorney for health care document is broader in applicability as it allows for a patient-appointed individual (the "agent" or "proxy") to make any health-related decision for the patient. Yet, providing specific guidance to the appointed decision maker is essential, if the appointed agent is to be able to make decisions that the patient would have wanted.

(continued on page 5)

Translating Ethics to End of Life Care Management

(continued from page 4)

GCM's can work with patients and families in beginning to consider what type of decisions the patient could face if their disease or condition advances. Is the question of intubation and/or long-term ventilation a realistic possibility? If so, and the patient would not want to be on long-term ventilation, would the patient choose to put limits on the length of time that ventilation would be tried? Would the patient be willing to consider artificial hydration and nutrition (AHN)? If so, is there a limit on how long and under what other medical condition the patient would want life sustained by AHN? There are several advance care planning guidelines or documents that might be helpful in discussing these questions with patients: for example, the Values History Form from the University of New Mexico Health Law Center; the Critical Conditions Planning Guide from Georgia Health Decisions; and Five Wishes. Bringing family members together to discuss preferences with the patient will help minimize the chance of lack of consensus among loved ones later, at the point where patient decisions need to be made.

Autonomy and Interdependence

Particularly in the United States, medical ethics decision making seems to prioritize respect for the patient's autonomy, or one's ability to make decisions about one's own care. JCAHO's patients' rights emphasis underlines the spirit of patients' independence in decision making. But how do individuals really go about decision making? I suggest that most people struggling with information and decision making about their health, choose to interact with others in their decision making process. Often patients talk at length with various health care professionals, sometimes asking a trusted professional, "what would

you do?" And often patients choose to bring family members or friends into their decision making process. Bart Callopy and Marshall Kapp have written about shifting concepts of autonomy in older patients. (Callopy, 1988; Callopy, 1995; Callopy et al, 1990; Kapp, 1987) When patients have limitations in some areas of their life, they may depend on others to help "implement" the decisions they have made or may even delegate decision making to another. In essence, decision making may become intentionally interdependent, with increased willingness to have family members or friends step in to help with health and other life decisions. This shift does not indicate a decrease in autonomous decision making, but rather a redefining of how one makes choices.

Acknowledging Your Values

As the GCM works with patients, family members and colleagues around these very difficult issues, understanding one's own approach to ethical decision making and one's values or beliefs about end of life treatment is essential. What does "respect for life" mean for you? What – in your opinion - would be a "good outcome" in this case? How independent are you in your own decision making? How do you deal with uncertainty in making decisions? Are there certain decisions that you could not support or participate in? What avenues exist for you to refer patients to other providers if you are no longer able to work with a patient? Do you have an ethics committee or other sounding board available to help you struggle with these decisions? The intensity of this work near the end of life necessitates that GCM's take care of themselves, just as they encourage family members to do. Beginning to acknowledge one's own limits, knowing when to take time away, and maintaining some balance between other and self-care is essential to being able to return to this work with integrity and energy.

Conclusion

In many settings GCM's may be uniquely positioned to help work with patients and families when an ethical issue is at stake. Underlying the wholistic medical and social issues that GCM's negotiate, are often issues of values and beliefs that may be unacknowledged. Using the language of ethics to help express these underlying values and frame how decision making might proceed in caring for a patient, can provide a powerful tool in end of life care decision making for patients, loved ones and health colleagues.

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Kathy Kinlaw is the Acting Director for the Center for Ethics at Emory University in Atlanta and directs the Program in Health Sciences Ethics. She also serves as the Executive Director for the Health Care Ethics Consortium of Georgia, and works with health care ethics committees statewide. In addition to the teaching of medical ethics, Ms. Kinlaw's scholarly work focuses on palliative and end of life care, public health ethics, and translating ethics into practice.

Ethics in the Business of Geriatric Care Management

Phyllis Mensh Brostoff, CISW, CMC

Introduction

Most geriatric care managers start their businesses after years of professional experience working with the elderly. They view themselves as responsible, ethical people, who are more likely to be intent on helping others than on making money. However, they did make a decision to start a business, although they do not always see themselves as business people.

GCM has had many conference seminars, and not a few articles published in this *Journal*, that explored the special ethical dilemmas that geriatric care managers face in providing care management services. Very few of these, however, have dealt with the ethical dilemmas that relate specifically to being a business owner. This article is an overview of these issues, directly referencing, where possible, the GCM Pledge of Ethics and Standards of Practice. Although it does propose some prescriptions for ethical business behavior, the principal intent is to provide a “heads up,” summarizing key questions a care manager needs to answer in managing an ethically sound business, and ending in a brief summary of how to approach ethical decision-making in a geriatric care management business.

Managing Employee-Employer Relationships

While the typical geriatric care management business starts as a solo practice, it is not unusual for the care manager to find herself with more business than she can handle – a dilemma many businesses wish they were facing. It does, however, pose an ethical challenge – if the care manager hires someone to help her, how does

she proceed? Standard 8 of GCM’s Standards of Practice states: “The PGCM should be familiar with laws relating to employment practices and should not knowingly participate in practices that are inconsistent with these laws.” Whether hiring administrative, paraprofessional or professional staff, the owner should check references, do a background check of licensing, police and driving records, and directly verify a number of documents such as diplomas, licenses, proof of citizenship or the right to work in the US. She should understand the difference between a W2 employee and a 1099 – and if she doesn’t she should learn this before she hires anyone. These basic elements of due diligence are required to protect the clients for whom the employee may have some responsibility – and the business reputation of the owner.

Administrative Staff If a care manager business owner decides to hire an administrative assistant, what should the owner do to assure that the assistant understands the importance of preserving the confidentiality of client records? What tasks can the care manager delegate to someone who is not a fully trained

care manager? These and related concerns require the owner to be clear about the job being filled, to make sure that every employee understands the importance of confidentiality and to provide any training that is needed to assure staff behaves appropriately.

Hiring Care Managers Even if the owner is hiring a fully qualified care manager to provide professional services, good practice requires written job descriptions that provide a clear understanding of responsibilities

and expectations for each job. This will go a long way towards assuring competent assistance to clients.

In addition, billing and compensation issues need to be addressed. Many geriatric care managers pay their professional employees on a billable hour basis – paying only for the hours the employee can document, and for which a client will pay. In either this model, or a salary compensation model, the business owner must have a plan to monitor the care manager to make sure that extra time is both necessary

and approved by the client or fiduciary. Should the employee care manager bill the client for time spent in

While the typical geriatric care management business starts as a solo practice, it is not unusual for the care manager to find herself with more business than she can handle – a dilemma many businesses wish they were facing.

(continued on page 7)

Ethics in the Business of Geriatric Care Management

(continued from page 6)

documentation, travel, and supervisory meetings with the owner? How does the owner compensate the employee for this time? Should the timeliness and completeness of documentation be connected to the reimbursement of an employee care manager?

Standard 10 – Continuing Education states: “The PGCM should participate in continuing education programs and be a member of his/her respective professional organization in order to enhance professional growth and to provide the highest quality care management.” The Pledge of Ethics states “I continue to improve my skills and knowledge by participating in professional development programs and maintaining certification and licensing in my profession.” Who is responsible for making sure that any professional training required to maintain a license or certification is received? Who should pay for this training, the owner or the employee care manager, and who should pay the fees to maintain a license or certification? What standards should be used to differentiate between this use of time, and how the employee should be compensated for time spent directly with clients?

Care manager business owners have hired employees who subsequently resign and “take” the clients assigned to them into a new practice. Can – should – the business owner have a “non-compete” or “non-solicitation” clause in the letter of hire or employee contract? How enforceable are these provisions and under what circumstances does the owner attempt to enforce these provisions? What is the role of client self-determination in a change of care managers? Do these provisions conflict with this Pledge of Ethics statement: “I will strive to assure cooperation between all of the individuals involved in providing service to you?”

If a care manager employee has a wide circle of contacts or is good at

marketing and generating new clients for the agency, should the business owner consider profit sharing with that employee? What should the compensation formula be?

Hiring Caregivers Many geriatric care management business owners decide to hire caregivers to work directly with clients, in response to client demand. The newest direction in health care is “client centered care”. The Pledge of Ethics states: “I will not promote or sanction any form of discrimination.” Is there an ethical dilemma when the client expresses distaste for a caregiver because she is overweight? What if the family insists that their parent can only be cared for by a caregiver of a certain racial, ethnic background or gender? Is there an ethical responsibility to the employee not to put her into a home with a client who has specifically stated that she will not allow anyone of the caregiver’s ethnic background to come into her home?

Does the business owner who hires caregivers have sufficient resources to adequately train and supervise them? Is there back-up when a caregiver is ill or on vacation so that she is not exploited and does not leave without notice because of burnout? How does the owner track overtime hours and does she pay for them?

Terminating Employees What does an owner need to know before firing an employee? Must she pay a terminated employee for vacation time that has not been taken? What practice should be followed, and what documentation should be kept, to minimize the risk of a discrimination lawsuit? Is there an ethically appropriate way to report the termination of an employee to other staff members? To clients?

Conflicts of Interest

Referrals Referrals are critical to the geriatric care management business. Most care managers believe it is a well established principle that an ethical geriatric care manager should not pay to obtain referrals. But Standard 13 – Disclosure of Business Relationships states: “The PGCM

should provide full disclosure regarding business, professional or personal relationships he/she has with each recommended business, agency or institution.” The GCM Pledge of Ethics states: “I will always provide service based on your [the client’s] best interest, even if this conflicts with my interests or the interests of others.” And under Referrals/ Disclosures, the Pledge states: “I will fully explain to you any business relationship I have with any service I propose, and give you information on alternatives, if at all possible, so that you, or a person designated to act for you, can make an informed decision to accept or reject the services I recommend to you.”

Thus, the “best thinking” in the association is that full disclosure of the relationship may allow for a care manager to be paid by a referral source. Does this provision also cover the purchase of a table at the annual Alzheimer’s Association fund raising banquet and allow for the acceptance of referrals from their call center? Should the owner give a gift to repeat referral sources during the holiday season? Is it appropriate for the business owner to accept gifts from assisted living facilities which make it clear they expect to receive referrals from the care management business?

Making Recommendations

When GCM began in the mid-1980’s, some considered it a conflict of interest for the care management business to also have a home care component. But, today care managed caregiving is an accepted model that provides clients with a service they need. [Full disclosure requires me to state that my agency provides care managed home care]. Does this mean that, in a disputed guardianship case, if the care management agency was asked to provide an appropriate plan of care, it is ethical to recommend one’s own home care agency or only another provider? Can the care manager include her home care service as one of the choices the court should know about, or would this constitute a conflict of interest, or the appearance

(continued on page 8)

Ethics in the Business of Geriatric Care Management

(continued from page 7)

of a conflict of interest?

Is it appropriate for a care manager to ask a client for the name of friends who might benefit from the agency's services? What about asking the person who pays the client's bills? Is there a difference between asking these two sources for referral "leads"? Should a care manager use an endorsement of her services for a fixed period only, or would continued use of the endorsement be ethical even if the business has not provided services to that family for many years?

Business Organization

Business Plans Many geriatric care manager business owners find one of the most difficult business tasks is writing a business plan. Having a written plan may make the difference between a successful business and one that fails. Writing a business plan forces the business owner to think about the goals of the business, a plan to achieve these goals and an understanding of the financial needs of the business.

Business Partnerships A gcm business owned by more than one partner or shareholder needs to have a buy/sell agreement in the event of the death or disability of one of the owners to assure operational continuity and avoid a disruption of client services. In addition, the owners need to agree on how they will make day-to-day business decisions, delegate responsibility, and resolve differences.

Succession Planning Even a sole practitioner should spend some effort in planning in the event of their disability or death. And all gcm business owners will presumably want to retire at some point – succession planning should be part of every businessperson's thinking.

Accounting Practices How much accounting knowledge should a care manager have before she starts a business? With the availabil-

ity of low cost and easy to use computerized accounting programs like Quick-Books, following standard accounting practices has never been easier, but having an accountant who is responsible for making sure that the all business taxes are paid, and on time, is also a requirement for running a sound business.

Business Advisors Having the right mix of business advisors may make the difference between the success and failure of a gcm business. In addition to an accountant, the business owner needs to have an attorney (possibly several, one with expertise in general business advising and another who specializes in employment law), marketing and public relations consultants, a strategic planning advisor, technology consultants and other specialists as the need arises. The key for the business owner is to recognize what she does not know and seek out the advice of those she can trust.

Billing Practices Billing practices can be a minefield for a care manager. Standard 11 – Fees for Service states: "All fees for professional geriatric care management services are to be stated in written form and discussed with the person accepting responsibility for payment prior to the initiation of services." This standard is probably met by most care management businesses. However, appropriate invoices, which accurately identify the work performed, fees charged, and sent at regular intervals, also are part of good business practices. Knowing how long to keep records, and keeping them in a way that maintains confidentiality, is also necessary.

Legal Documents A geriatric care management business must have proper legal documents, such as employee contracts, client contracts or service agreements, methods to document compliance with paying taxes, and consultant agreements that maintain client confidentiality. However, the care manager business owner also wants to make sure that documents given to clients, such as a service agreement, are written in plain English, not

legalize or professional jargon, so they are understandable to clients.

Marketing and Public Relations

Advertising Care manager business owners have developed a variety of methods to market their businesses. But how carefully should they consider what to say in their brochures? Standard 12 states: "Advertising and marketing of services should be conducted within all guidelines and laws governing the advertising of professional management services." Does this allow a care manager to claim their services are "excellent" without identifying the basis for making this statement, such as client satisfaction surveys? Should the care manager try to add additional expertise to the services she offers through specialized training? Who decides if she is sufficiently expert to advertise a particular specialization?

Relations with Others If a care manager owner believes that another individual she knows is providing a service for which she is not trained, should the care manager report that person to a licensing authority? Should the business owner provide pro bono or volunteer service, and if so, how much? Has she arranged for coverage for her clients if she is on vacation? If a care manager is soliciting business from an attorney or bank trust officer, what should she do if they offer to transfer a client who has been served by another care manager? How should a care manager respond to a request to comment on a competitor? If the business owner receives a call from the media asking to speak to a client, should she ask one of the clients or families who has given her permission to use them as references? Can she assure the client that she would not be exploited for the sake of the reporter's story?

Resolving Ethical Challenges

A geriatric care manager business owner can use the same method
(continued on page 9)

Ethics in the Business of Geriatric Care Management

(continued from page 8)

she uses to resolve an ethical dilemma concerning clients to resolve the business related issues I have raised here:

- first identify the facts;
- then decide which ethical principles may be involved;
- consider alternatives, try one out, review how well it worked, revise, and try again.

In the end, a care manager who owns her own business is perhaps best guided in resolving the kind of issues raised here by asking herself this question: "what would I want done if I were the client, the fiduciary, the referral source, the employee, the business partner?"

Owners of care management businesses who seek out seasoned business and professional advisors whose professional expertise and judgement they can trust; who anticipate issues and refer to the association's Pledge of Ethics and Standards of Practice as they develop their systems; who discuss concerns before they act; who consider the advice they receive; and who act on the premise that "your last mistake is your best teacher," can run successful businesses based on sound ethical principles.

Phyllis Mensh Brostoff and Valerie Stefanich co-founded Stowell Associates SelectStaff, in 1983 in Milwaukee, Wisconsin. The agency provides geriatric care management and caregiving services to the elderly, disabled adults and their families. Phyllis was a founding member of GCM, served on its Board from 1986-1991 as the first Treasurer, and re-joined the Board in 2000. She has been the Secretary of the Board since 2005. Phyllis was also on the GCM committees which wrote the Pledge of Ethics and drafted the Standards of Practice. She has written numerous articles and presented many seminars on geriatric care management and ethics.

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Strategies for Resolving Ethical Issues in Geriatric Care Management

Ray Moseley, Ph.D.

Rona Bartelstone, LCSW, BCD, CMC

Geriatric care managers often find themselves torn between conflicting ethical values, such as maximizing client autonomy and doing what is perceived to be in the client's best interests; serving the client's needs and satisfying the business goals of the case manager's employer; and maintaining client confidentiality and revealing client information to others that may

want or need that information. We argue that although codes or pledges of professional ethics may offer general guidance in resolving these ethical conflicts, the geriatric care manager must master the skills of critical ethical analysis in order to apply general ethical codes to particular cases and situations.

Substantive Values

Many professional groups have codes of ethical behavior and conduct. Like these other professional ethical codes, the code of ethics for geriatric care managers emphasizes duty to the client and confidentiality of information and avoidance of conflicts of interest. These moral rules directly reflect the basic ethical principles of autonomy, beneficence and justice. These general principles are useful for identifying and categorizing ethical issues

Many professional groups have codes of ethical behavior and conduct. Like these other professional ethical codes, the code of ethics for geriatric care managers emphasizes duty to the client and confidentiality of information and avoidance of conflicts of interest.

but they are also generally non-controversial in this role. Identifying the relevant ethical principle involved in a case may also give some indication of the type of problems that may come to light in the resolution of the particular case. However, in actual practice we often discover that these principles give us only a false sense that the ethical problem has been addressed. The fact is that with

most ethical problems these principles are in conflict, or lack clarity in their application, and are thus of little value in themselves for solving a practical everyday ethical problem. For example, the case of the person who has mild cognitive impairment, limited vision due to glaucoma and macular degeneration, but who continues to drive despite having had several minor accidents. In this situation, the basic ethical principles might make it seem clear that as long as the person still has capacity (not yet determined), that s/he could continue to drive. However, if we were to introduce broader societal values and consequences, the situation might be viewed very differently. In other words, the situation must be looked at within the context, not only of loyalties and principles, but also of situation and values.

Procedural Values

In order to effectively and consistently resolve everyday care management ethical problems it is essential to have not only basic knowledge of the substantive moral values, but also the necessary procedural skills to apply these principles in ways that effectively resolve real life ethical problems that face geriatric care managers. Although codes emphasize substantive moral values and moral rules, unfortunately they largely ignore procedural values and processes. The reason this is the case is that procedural values do not nicely lend themselves to bullet point rules that are the mainstay of most professional codes.

If geriatric care managers are to make effective ethical decisions, they must embrace and practice procedural values which include:

1. "Critical analysis" is the art of identifying and explaining reasons for and against various courses of action. This is amazingly difficult sometimes since most of us make moral decisions in a way that does not clearly identify underlying basic moral principles or specific reasons for a proposed resolution. Ethical resolutions are often made on a "gut" level and express personal values and bias and not well-reasoned and analyzed arguments. The only way to learn critical analysis of ethical problems is to engage in open dialogue and discussion of these problems.

Using the example above, of the person who wishes to maintain

(continued on page 11)

Strategies for Resolving Ethical Issues in Geriatric Care Management

(continued from page 10)

her autonomy by continuing to drive despite certain limitation, one needs to look at the issues of:

- Her current capacity to make sound judgments;
 - Her desire for autonomy;
 - Issues of public safety vs. individual rights;
 - Our loyalty to the client to represent her interests;
 - Our liability for our recommendations within our plan of care;
 - Potential consequences for the client's continuing to drive
 - The availability and cost of alternative means to meet the client's needs.
2. An essential procedural value for ethical problem resolving is that ethical arguments and decisions must be evaluated in an "objective" and "open-minded" manner, without preconceived bias. The common operative way ethical problems are addressed is that someone already knows (through their intuitions or emotions) the "right" ethical answer. However, this approach just leads to the rationalization of a particular ethical resolution. In other words the only reasons that are discussed, if in fact any reasons are given, are those that support the resolution that was desired. In political discourse and debate this is the common mode of operation, one gives only reasons that support the resolution that is desired. Other possible resolutions are simply ignored
- In practice what this means is that discussion of ethical problems must allow all arguments and reasons to be fairly presented and analyzed. The validity of the reasons determine the resolution of the ethical problem, not the personal, political or emotional aspects of the case. This is

amazingly difficult to accomplish sometimes because it means that "conventional wisdom" must be challenged, and even more difficult to admit and face is that it might mean that we have been wrong about an issue.

3. Another crucial procedural value is that reasoning must be "transparent" if we are to minimize potential conflicts of interests. This means that persons involved in analyzing ethical problems must reveal potential conflicts of interests to all potentially affected parties. For example, is there a monetary benefit to the care management company if the client gives up driving and requires a transportation or home care service to fill the new need? If there is a benefit, either directly or indirectly, has this been disclosed and discussed with the end user and the person responsible for paying for the service? Have other options for meeting the need been provided to the client system?
4. Sometimes it is difficult to distinguish particular values that are ethically derived from those that are culturally determined. In fact, this is a difficult and ongoing debate among ethicists, anthropologists and others. However, it is clear, no matter what our position is on this debate that those involved in resolving ethical problems must be sensitive to the culturally relevant values involved in a case. At the very least the care manager must be aware of the values held by their client and take those values into account in any deliberation of ethical problems that might arise.
- This is true with daily issues of care involving lifestyle decisions and faith traditions - Whether it is a question of how one cares for a cold, the way that one keeps house, or the celebration of holidays and special events. Often the quality of life for someone needing chronic care comes down to helping that

person to continue to feel comfortable in their own setting. As caregivers we may tend to think about the more dramatic end of life issues and neglect the daily routines that are the sum and substance of life.

Geriatric Care Management: Practical Ethical "Procedural" Pearls

1. Geriatric care managers should make it a routine matter to talk about end-of-life issues with clients sooner rather than later. Like most of us in our society even geriatric care managers may not like to talk about end-of-life issues with their clients. There is the fear of upsetting the client and family or sending the message that death is imminent. Although studies have indicated that this fear is largely unfounded, reluctance persists. However, end-of-life issues are the source of many ethical issues facing the geriatric population and are much easier to address while the client is capacitated, has time to think about the issues and discuss them with relevant family and friends. These discussions should be documented in the care managers' plans.
2. A specific end-of-life issue is worth additional comment. The geriatric care manager should clarify ambiguities in a client's Advance Directive as well as the identity, location and status of the client's surrogate decision maker. It is important that the client understands that they should chose a surrogate that knows the clients end of life treatment wishes and has agreed to espouse those wishes to the appropriate physician if the client becomes incapacitated. Too often a person chooses a surrogate without considering if the surrogate is ready and willing to present and advocate the client's wishes. It is also critical to help the client and the surrogate

(continued on page 12)

Strategies for Resolving Ethical Issues in Geriatric Care Management

(continued from page 11)

understand and document that Advance Directives are more than just a “DNRO” (do not resuscitate order). In a recent counseling session with a client who was appointed as the health care surrogate for her husband, she began to deal with facing end of life healthcare decisions. Several times she alluded to her husband ending up on a feeding tube because of his dementia. When it was pointed out to her that that could only happen if

agreement to accept the plan, it also means that the care manager gives all relevant information about the plan and other alternatives, that the client understands the care plan and that the client is not feeling coerced into accepting the plan.

With informed consent just as with all other substantive and procedural values the language we use to talk about ethical issues is important and reveals the seriousness with which we take ethical decision making. In this context the care manager “asks” for the client’s informed consent. “Getting informed consent”, “acquiring informed consent”

to help families with caregiving, it becomes especially important for the care manager to involve the client in actively accepting the plan of care because they did not have a say in the initiation of the relationship.

4. Even if a client is not adequately capacitated to give informed consent, client “assent” is still important. Asking for agreement from a client even if the person is not completely capacitated and even if a next of kin is the legal decision maker recognizes that a person’s autonomy and decision making ability is not an all or nothing concept.

An example of this is the client who wanted to have eye surgery to improve her vision despite having some dementia and other complicating health problems. Her physician was reluctant to perform the surgery, unless her daughter (the healthcare surrogate) fully understood that the surgery had risks for her general health.

What we did with this client was to have a discussion with her at different times of the day, with different people present to review the possibility of the risks and rewards of the surgery. As part of this process, we strategically discussed the issue with the client at different times, when her cognitive abilities might be inconsistent. We also involved her daughter, other family members, and the nursing staff of the facility in which she lived. Lastly, we assiduously documented each conversation, its content and outcome. This was useful to the daughter, who then did not feel the sole responsibility for the decision and gave the physician comfort that this was a valid decision of the patient made over time and with the exploration of risks and alternatives. It also actively confirmed that this client, despite some cognitive losses, was consistently willing to accept

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she, as his surrogate, would approve such life prolonging measures. This led to an in-depth discussion of what he had expressed as his end of life choices and what it means to make healthcare decisions at the end of life, many aspects of which she was unaware. This also opened up the opportunity for her to discuss these issues with her husband’s other close friends and relatives, so that she could have support, as well, when it comes time to make those decisions.

3. When the geriatric care manager develops a care plan for a client it is sometimes presumed that the client will of course agree and accept the plan. In fact, the client should be asked to provide informed consent to the care plan. Consent in this context is more than just the

language should be avoided as it does not recognize that consent implies that a client might say “no” and that the “client does in fact have a choice!”

In other words, the client must actively accept the plan of care rather than just passively accept what is imposed by the care manager or another “authority” figure. This may not always be easy to achieve, especially when you have a situation of questionable capacity or a “resistant” client. In fact, there have been times that care managers have used what is characterized as the “therapeutic fib” to gain access to a client who is struggling to maintain independence and privacy. The fib might be that I am a “friend” of the family or that I was sent by her doctor because of his concerns. When it is deemed to be necessary to do this

Strategies for Resolving Ethical Issues in Geriatric Care Management

(continued from page 12)

the risks of the surgery if there was a possibility of improving her vision.

5. Develop a network of support and advisors that can offer you advice and support on ethical issues you will face. Consider developing an ethics committee for your care managers' group.

In fact, having an ethics committee can serve multiple purposes for the National Association of Professional Geriatric Care Managers members. The availability of an ethics committee could potentially be a chapter function for members. This would provide support for the Practice Standards and the implementation of the Pledge of Ethics and would help with assuring the integrity of members and providing a means of giving critical feedback to members with questionable practices.

Furthermore, those care managers who have a certification in care management will need to have continuing supervision or consultation. Therefore, an Ethics Committee could provide a component of that requirement for members.

6. Explicitly discuss ethical issues in care management meetings. Additionally we argue that care management businesses and organizations must make the identification and resolution of ethical problems a significant part of the institutional structure.

This includes the need to have structured means to document the process of ethical decision making in complex situations. Having the ability to use critical thinking skills and the exploration of alternatives for client plans of treatment is a major role of care management staff meetings and

in-service trainings. For those who are individual practitioners, they need to find a mechanism for continually reviewing the ethical dilemmas that arise in daily practice. Therefore, a chapter ethics committee or a virtual ethics committee through GCM might be a valuable member benefit. Furthermore, these sessions should also be documented by the care manager to assure accountability for objective, ethical decision making.

Conclusion

It is not enough to have knowledge of basic ethical principles. Rather it is mandatory that care management practices take into account in a structural way mechanisms that will facilitate the review of ethical dilemmas that arise on a daily basis. This means that practitioners must routinely do the following:

- Review the Pledge of Ethics, Standards of Practice and Statement of Core Values that GCM has published for the purpose of actively applying them to client care situations. These documents and their application to client situations, must be a vital part of each care manager's practice;
- Make ethical considerations an active part of all case consultation, staffing, continuing education and supervisory sessions;
- Consistently be honing their skills of critical analysis, which includes being open to the values, preferences, lifestyles and faith traditions of all members of the care team;
- Proactively help the client system to resolve internal conflicts of interest through a process of open communication, exploration of values, potential consequences and the reality of each person's (and each community's) resources and capabilities;

- Have a team of experts who can assist with both the determination of situational capacity and the process of analyzing ethical dilemmas;
- Cultivate resources to provide alternative means of meeting people's needs when they can no longer be met internally by the client system;
- Learn and practice appropriate documentation for the analysis of ethical dilemmas in order to demonstrate adherence to professional standards and to mitigate liability.

Taking these steps will help to assure that care management businesses and organizations make the identification and resolution of ethical problems a significant part of their institutional structure. This in turn, will help to assure that each practice is prepared to balance client needs with business needs, as well as balancing the needs internal to the client system and the community. By creating an internally sound structure for handling ethical dilemmas, care managers advance the evolving discipline toward the professionalism for which it is striving.

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Geriatric Fiblets - Necessary White Lies or Bad Therapeutic Technique?

How to do an ethical query for your own practice

*Cathy Jo Cress, MSW
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Lying, according to Mark Twain, happens all the time. “Everybody lies – every hour; every day; awake; asleep; in his dreams; in his joy; in his mourning.” Twain’s literary take on society’s age-long deception allows us to consider: is this true, and, if so, is it right or is it really wrong? We, as PGCMs, go even further down the rabbit hole as we work with the dementia client. There is now a specific type of lying, defined in the last few years as the “geriatric fiblet.” This article will look at the ethics of lying – the ethics of lying to demented clients and recent research on the phenomenon of lying itself. Lying has become a much discussed topic since since 9/11, the advent of Homeland Security and the release of films such as “Good Night, and Good Luck,” which portrays McCarthy-era lying. Our society is again looking at the ethics of lying and spying. This article explores the ethics of lying to a specific group in our society, people with dementia.

What is a geriatric fiblet? Canadian Susan Hart, at the World Alzheimer’s Congress in 2000, defined the concept of geriatric fiblets: “necessary white lies intended to redirect loved ones or discourage them from continuing detrimental behavior.”

Geriatric care managers have debated this new concept and the ethical dilemma it creates on the GCM listserv and in their practices. This article is intended to review the

Let us begin with a sample situation. Wilhelm Remer lives with his daughter Amy in San Luis Obispo, California. He has moderate dementia. One day he wanders out while his

daughter is exercising in her basement. He carries away their new kitten, recently rescued by the local SPCA from New Orleans. The neighbors see an old man walking with a cat, two blocks from his home, and call the police. The police see his Alzheimer’s bracelet and call Amy. When she arrives, the traumatized cat is under the police car. Wilhelm has told the police he is going back to Atlantic City, New Jersey, with his cat. Amy tells her father a white lie, “Dad, isn’t it great you just rescued that kitten? Let’s take it back home so you can feed the cat before you go on your trip. Then I’ll help you pack.”

As human beings, we have a system of ethics that tells us not to lie. Where do we get this ethical system? We absorb it from our parents, religious groups and our society, according to Edgar Schien (Cress, 2001). What does this system of ethics include? Ethics 101: “Tell the truth.”

As adults and professionals, we

(continued on page 15)



Wilhelm Remer on his 85th birthday

literature around geriatric fiblets – or lying to demented clients – and present the pros and the cons of this practice so that PGCMs can better form their own ethical points of view.

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Geriatric Fiblets - Necessary White Lies or Bad Therapeutic Technique?

(continued from page 14)

often join groups and agree to abide by those groups' systems of morality. In the National Association of Professional Geriatric Care Managers this is exemplified in the GCM Pledge of Ethics. Although the GCM pledge does not at this time directly address lying, the section on Substitute Judgment could be construed to address it indirectly: "I will not substitute my judgment for yours unless I am acting in the role of your guardian, appointed by a Court of Law, or with your approval, or the approval of someone designated to act for you."

In addition, the GCM Standard of Practice No. 10 encourages PGCMs to adhere to the standards and practices of their respective professional organizations. The NASW Code of Ethics addresses the topic under "Dishonesty, Fraud and Deception" (Code 4.04): "Social workers should not participate in, condone, or be associated with dishonesty, fraud or deception." At some point GCMs may decide to address this new ethical dilemma directly.

The GCM's Pledge of Ethics and the basic Ethics 101 system that we are taught by our parents, community

groups (Girl Scouts, church, etc.) and general society provide us with our moral code. John Banja, a noted writer on ethics and case management (Cress, 2001), tells us that there is a basic system that drives every group (including GCM), defining that particular group's moral concepts and conveying to group members how they should behave. When we look at



New Orleans kitty, Nod

the moral concepts in a group such as GCM, we begin to discover whether that group's moral system is defensible or acceptable. We are then, according to Banja, entering the world of "ethics."

Banja tells us that we can adapt Beauchamp and Childress' Principles of Biomedical Ethics for care management. Within this ethical map are four accepted guides to ethical decisions. Although these are the accepted ethical principles in medicine, we can also apply them to geriatric care management (Cress, 2001).

These guiding principles are:

Beneficence – Advancing an individual's benefit

Justice – Acting in fairness and equitably giving clients the services they need

Autonomy – Respecting the client's worth

Non-maleficance – Refraining from harm

Banja tells us that these four principles need to be in balance with each other and that no principle can supercede another. When one of these four principles collides with another we are entering the world of the "ethical dilemma."

Ethical dilemmas occur when a group's moral code or fabric is reduced to its policies and it's understanding of what is right or wrong (my parents told me not to lie – GCM tells me to tell clients the truth). When these understandings are questioned as to whether that moral

code is defensible, coherent, honorable and fair (Cress, 2001), we are taking an ethical dilemma and testing it through an ethical query. For example, if Beauchamp and Childress' principle of beneficence – doing the greater good for older people – is a goal, is it ethical for the federal government to cut back on Medicare and Medicaid services in the upcoming budget?

In the case of lying, our parents' moral code is telling the truth and our group's professional moral code is being honest with clients. When we work with demented clients, this moral code may be perceived as doing our demented client more harm than good. Taking Beauchamp and Childress' principles of medical ethics, what we may have is an ethical dilemma – the principle of 'beneficence', doing the greatest good – colliding with 'justice', which includes telling the truth.

Let us use an ethical query on our

(continued on page 16)

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Geriatric Fiblets - Necessary White Lies or Bad Therapeutic Technique?

(continued from page 15)

client Mr. Remer and his daughter Amy. We'll have Amy use four different therapeutic techniques to get Dad back to his present home, Amy's house in San Luis Obispo. First, let's have Amy tell him a geriatric fiblet: "Dad, isn't it great you just rescued that kitten? Let's take it back home so you can feed the cat before you go on your trip. Then I'll help you pack." Looking at what would bring Mr. Remer home safely and calmly and what actions on Amy's part would give him the greatest sense of dignity, here we are using the principle of beneficence.

Is this geriatric fiblet told by Amy stopping Mr. Remer from detrimental behavior? This "white lie" may stop her Dad from further arguing and the resulting agitation because Amy is accepting his reality (I live in Atlantic City and my cat and I need to go home). Is she able to get him safely back home without the agitation caused by the police having to get him in the police car, kicking and screaming? Will this therapeutic technique result in Mr. Remer being calmer when he does get home? Is the geriatric fiblet working in the client's best interest, holding up Beauchamp and Childress' principle of non-maleficence? On the other

hand, is Amy's geriatric fiblet undermining the trust that is an essential element of the caregiver-client relationship? Amy will probably not pack his bag and send him to New Jersey when she gets home. If he does remember she said she would pack the bag, does this undermine trust (autonomy again)?

Is the geriatric fiblet really something that is helping the caregiver (Amy) rather than Mr. Remer? In this case it appears that the technique may help both caregiver and client because neither has to become agitated and Amy and the police don't have to force their will on Mr. Remer. With this consideration, are we following the principles of justice – to tell the truth – and in the GCM code of ethics, loyalty (our client is Mr. Remer)? Or does Amy's geriatric fiblet help maintain his autonomy because getting

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him home safely will prevent escalation of caregiver burnout and possible premature placement of her Dad? Further, do we have a collision of autonomy/trust and non-maleficence – refraining from harm? Amy is lying to her Dad and will not take him back to Atlantic City, but she will do him the least harm by getting her Dad and the frightened cat calmly and safely back to her house two blocks away.

Let's try another version of this scenario: the therapeutic technique of "reality orientation," which suggests that the client be reminded

of and oriented to time and place (Stanford, 1995). In our reality orientation version, Amy will tell her Dad he does not live in Atlantic City but lives in San Luis Obispo. She will tell him she sold his house 15 years ago when his wife, Amy's Mom, died.

Let's explore this approach. Is this reality orientation statement really for Amy or for her Dad? Is Amy so frustrated by his care and her escalating caregiver stress that she is using reality to let off steam rather than considering how it will affect her Dad? Is she so mortified to have neighbors watching the police, her Dad and her from drawn curtains? This may address Beauchamp and Childress' principle of justice and the GCM Code of Ethics statement about loyalty.

Will using reality orientation escalate Mr. Remer's anger and agitation because Amy is confronting his confused reality (I live in Atlantic City)? Does this approach conflict with Beauchamp and Childress' principle of non-maleficence – refraining from harm? Will this technique get Mr. Remer so agitated that it will result in more caregiver stress and put Amy on the edge of placing her father – thus endangering his autonomy? So through reality orientation we are both respecting the client's worth (autonomy) and promulgating justice (telling the truth). But are these two principles colliding with non-maleficence (do no harm) because they agitate him further by confronting his confused reality and risk his autonomy by putting him at risk of placement?

Let's reframe this scenario with Amy and her Dad using the therapeutic technique of "validation therapy." This type of therapy, developed by Naomi Feil in the 1960s, is based on recognizing and validating the emotions underlying the anxiety of the demented person. Feil believes that when current

(continued on page 17)

Geriatric Fiblets - Necessary White Lies or Bad Therapeutic Technique?

(continued from page 16)

reality becomes too confusing or painful, the older person needs to return emotionally to a happier period of life and will benefit from the opportunity to talk about comforting things from the past – his or her old home, family and former reality. However, Feil does not believe in using therapeutic lies to dispute current reality; while such lies may divert or temporarily placate an anxious demented person, she feels they are patronizing, erode trust and do not address the needs that caused the behavior (Feil, 2002).

Validation therapy tells us not to lie but to validate Mr. Remer's need for his former, more pleasant reality (Atlantic City in the summer of the 1950's). Using this approach, Amy might say, "Dad, Atlantic City was so much fun in the summer, wasn't it? You were such a good Dad, taking us to the beach. We had a kitty like that one under the police car. Do you think it might be hungry? Should we take it home and feed it?" In the validation therapy approach are we increasing Mr. Remer's agitation, as Amy is confronting his reality (I live in Atlantic City)? Is this approach following Beauchamp and Childress' principle of non-maleficance and the GCM ethics pledge's principle of loyalty? Might using this validation therapy approach further threaten Mr. Remer's autonomy because continued wandering and escalated caregiver stress in Amy might lead her to place her father in a SNF? Or are we committing a sin of omission because we are ignoring the reality Mr. Remer currently accepts, that he lives in Atlantic City?

Lets' try another version of this scenario using a therapeutic technique called "Aikido." Aikido also tells us to look at the client's deeper mental world rather than correcting the demented person or confronting

their reality. This approach sidesteps the client's reality and looks for the deeper truth or underlying emotions causing the problems, instead of angrily stating the reality or the facts of the situation. Aikido uses "I" words and attempts to involve the older person in finding a solution (Shellenbarger, 2004).

Using an Aikido approach, Amy says to her Dad, as the policemen and the frightened kitty look on, "I know, Dad, it's hard living here in San Luis Obispo. You lived for 70 years in Atlantic City and you don't live there anymore. What can I do to make it easier?" Is this Aikido method building trust because Amy is acknowledging how hard it is for her Dad to give up his independence (the biomedical ethical principle of autonomy)? Is the Aikido method again helping to maintain Mr. Remer's autonomy because Amy is entering into an adult relationship with her Dad by acknowledging his present loss of independence? Can this filial maturity

agitated because she is denying his reality (it is 1950 and I live in Atlantic City)?

Let us return to Twain's statement that lying happens all the time. Robin Marantz Henig's article, "Looking for a Lie" (Henig, 2006), explored lying and new developments in our ability to track it. Ms. Henig cites the Twain remark and then says that lying appears to be endemic in every society; it is built into the social weave and warp of our society. She cites the pervasive sin of omission. For example, you go out to dinner with a fellow geriatric care manager. The PGCM brings a new boyfriend who behaves obnoxiously. The next day at work, you and the PGCM talk about how good the food was at the restaurant and you refrain from discussing the nasty boyfriend.

Henig says the fabric of our society is also woven deep with sins of commission. Your Mom gives you a new blouse with 80's padded shoulders that you will never wear. You say,

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on Amy's part reduce caregiver stress and burden that could escalate into her placing him, thus protecting his autonomy?

Is this Aikido method perhaps stopping Mr. Remer from further detrimental behavior because his daughter is hearing his loss and pain? Will this acknowledgement stop Mr. Remer from escalating agitation with the police and Amy thwarting his journey back to Atlantic City (non-maleficance)? On the other hand, since Amy is clearly making a statement that he does not live in Atlantic City anymore, will he become more

"Mom, this is just perfect." You have just committed a sin of commission. According to Henig we learn to lie at about age 3 or 4, and our first lie is probably to our mothers: "It wasn't my fault." UC Santa Barbara psychologist Bella De Paulo says, "Lying is just so ordinary, so much a part of our everyday lives and everyday conversations." Henig posits in her article that it might be destabilizing to us as humans to be stripped of all half-truths and delusions on which our social life depends.

(continued on page 18)

Geriatric Fiblets - Necessary White Lies or Bad Therapeutic Technique?

(continued from page 17)

Trust is an essential part of the doctor-patient relationship and of the geriatric care manager-client relationship. In any psychological patient relationship, trust is critical.

It has always been a basic therapeutic premise that mutual trust cannot be built on deception. Once lies are started they have to be continually escalated, which leads to harm and malfeasance (Marzanski, 2000). However, on the other side of this coin, therapeutic relationships with demented patients are difficult to establish. In addition, geriatric care managers frequently work through a third party – an adult child caretaker or a care provider – because the demented client is not with us 24/7

and many times we do not see that client often enough to build trust. So with whom do we build trust – the client, or the caregiver child or care provider? We certainly do not want to lie to the child or the caregiver, so are we justified in teaching both the adult child and the caregiver to present geriatric fiblets for the client's good, and, if we do so, are we endangering trust?

Now let us look at Therapeutic Privilege. Marzanski states that benevolent deception has long been a tradition in medical practices but has been criticized as being pater-

nalistic (Marzanski, 2001). However, he states that with the dementia patient, benevolent deception, using therapeutic privilege, may be unavoidable because anxiety, depression, catastrophic and psychotic reactions can occur as a result of disclosure (“I sold your house 15 years ago and Mom is dead”). According to Borchert and Stewart in their book *Exploring*

Ethics (Borchert & Stewart, 1986), lying degrades dignity and due respect. However, they state that ethicists generally agree that non-malfeasance – doing no harm – may override the principle of veracity with demented patients. On the other side of the argument, many PGCMs consider people with dementia still persons who deserve affirmation of their personhood. Patients with dementia are to be treated with dignity (au-

tonomy, respect of the client's worth), and lying degrades a person. Here again you have an ethical dilemma that needs to be sorted out by GCM, and by each PGCM individually.

There are two ethical theories that apply to lying, as cited by Marek Marzanski (2000). One theory is Deontology, which assumes that lying and deception are wrong and clinicians (and care managers) have a moral duty to tell the truth. A second theory, Consequentialism, puts forth that the decision to tell or not to tell the truth depends on the

details of the clinical situation, and that the professional should decide which path to take based on the least harmful path (non-malfeasance) that will produce the best results.

So here the professional geriatric care manager must decide if using geriatric fiblets with an Alzheimer's patient (“We will take this hungry kitty home and feed it, then we will pack”) is the least harmful path for Mr. Remer, or if the deontologically-based reality therapy (“You do not live in Atlantic City anymore – we sold your house 15 years ago”) is the best path. Finally, we need to explore who the client is in this situation. With many Alzheimer's clients we have family members who, like Amy, are care providers. Are these family caretakers meeting their own needs instead of the demented client's? Using reality therapy (“You do not live in Atlantic City, Dad. I sold your house 15 years ago and Mom is dead. Can you please just get it together?”), Amy is frustrated with the care of her father, suffers from caregiver burden and is perhaps lashing out.

Let us look at the dynamics of change through a systems approach, from the adult child's perspective. Frequently adult children such as Amy are caring for aging, demented parents but have previously unresolved conflicts. When an adult child needs to care for parents, as in the case of Amy and her father, there can be a shifting power dynamic between the parent and adult child. When this role reversal takes place, adult children can experience fear of losing that old internal parent who took care of them, and subconsciously lash out at the parent(s) for leaving them.

According to the theory of filial maturity, originally developed in the '60s by Margaret Blenkner (Braeckmans, L. & Marcoen, A., 1998), at this new stage of life, the adult child enters into a changed relationship with the parents. This is not a role reversal, but an altered relationship requiring the adult child to respect

(continued on page 19)

Trust is an essential part of the doctor-patient relationship and of the geriatric care manager-client relationship. In any psychological patient relationship, trust is critical. It has always been a basic therapeutic premise that mutual trust cannot be built on deception.

Geriatric Fiblets - Necessary White Lies or Bad Therapeutic Technique?

(continued from page 18)

their parents' autonomy, even as their parents are becoming more dependent on them. According to Blenkner, adult children have two parents. The first parent is the internal parent they grew up with, who may have either been a good, caring parent or a perceived bad parent. These internal parents hover in our mind as the embodiment of the Mom or Dad we had as a kid. Then we have the present parent, such as Mr. Remer – now aged, demented and dependent on Amy – causing real-time frustration and anger.

Paul Ekman, an expert on lying and an Emeritus professor at UCSF, states that therapeutic lying is very difficult. He posits that people who lie need to be able to think strategically, plan their moves ahead, read others' needs and put themselves in their shoes, "like a good therapist." As PGCMs sensitive to our client's needs, we are in a position to help bridge the two realities they often drift between – the comfortable old past (Atlantic City) and the sometimes frightening present (San Luis Obispo). Their adult caretakers also drift psychologically, according to Margaret Blenkner, between their old internal parent (Atlantic City) and their present parent (San Luis Obispo). As professionals well-suited, according to Eckman, at re-

As PGCMs, let us help our older clients, their families and caregivers, as they move closer to death, walk toward it as Dylan Thomas implored, "Go gently into that good night." May we discover through further research as PGCMs if therapeutic lying might make that path ethically more gentle.

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"What am I doing dealing with this mess out here on the street with the police and my new kitty, when you, Dad, were an awful parent to me?" In either case the adult child has two realities of their parent.

Sometimes while dealing with present-day frustrations, the adult child will yearn for their old internal parent who cared for them, instead of this embarrassing, difficult parent. Or they can say to themselves, "What am I doing dealing with this mess out here on the street with the police and my new kitty, when you, Dad, were an awful parent to me?" In either case the adult child has two realities of their parent. The geriatric care manager's job as a professional is to facilitate this filial maturity and help the adult child accept the present parent. Part of that acceptance may be helping them refrain from lashing out with reality therapy by using therapeutic lying to cushion the situation for their parent ("Let's go home and feed the kitty and then we'll pack"). These are "kind-hearted lies" – lies to help protect someone's life or feelings (Henig, 2006).

forming the truth, perhaps it is time for PGCMs to use that skill to help demented clients and adult children move toward the most healthy reality, which may not always be the present with the older demented client and surely is the present parent for the adult child.

Finally, the care provider, who is in the care setting more frequently than either the PGCM or the adult child, needs to be counseled and educated on geriatric fiblets. As lying is so difficult, according to Eckman, there needs to be ethical education given to care providers by PGCMs as to when therapeutic lying is in the interest of the client.

Euripides tells us, "Old men's prayers for death are lying prayers, in which they abuse old age and long extent of life. But when death draws near, not one is willing to die, and age no longer is a burden to them."



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