

**Long Term Care  
Intensive Train-The-Trainer Series**

**Ethical & Legal Concerns**

Copyrights

*Authors:* Carol Barker, Ph.D., R.N., and Mary Foerg, CSW, ACSW ©  
Hospice of Michigan

*Editor*

Jennifer Mendez, Ph.D.  
Institute of Gerontology – Wayne State University

*Presented by:*

**Institute of Gerontology  
Wayne State University**

*In partnership with:*

Hospice of Michigan

**The development of this training manual has been funded by a grant from the  
*Michigan Department of Community Health Long Term Care Initiatives***

## Ethical & Legal Concerns (Slide 1)

### Module Overview: (Slide 2)

Advances in medical technology, changes in social and family systems, the advent of managed care, and an unlimited array of healthcare choices have added to the complexity of end of life care. Ethical dilemmas on macro and micro levels emerge as the debate on extending life versus prolonging death continues.

### Definition of Terms: (Slide 3)

**Consent** – Agreement of one person to accept actions of another on their behalf

**Surrogate** – One who is formally designated as decision maker for patient care.

**Disclosure** – Revealing information about illness or treatment

**Beneficence** – Act in patient's best interest

**Autonomy** – Resident self-determination

**Nonmaleficence** – Do no harm

**Justice** – Fair allocation of resources

**Euthanasia** – Causative agent of death is directly administered by another

**Double Effect** – Involves taking an action intended to have a good effect, with a known harmful effect.

### Objectives (Slide 4)

1. Describe the healthcare provider's role in addressing ethical issues
2. Explain concepts of confidentiality and disclosure
3. Identify four principals of medical ethics central to end of life care
4. Become familiar with phrases "euthanasia: and "physician assisted suicide"
5. Describe the Hospice Medicare Benefit
6. Identify two types of advance directives
7. Identify resources for addressing ethical dilemmas



Teaching Cues	Content	Resources
<p>“Capacity” should be emphasized</p> <p>“Surrogate” should be emphasized</p>	3.0 Issues of decision making and communication	Slide 8
	3.1 Consent is the agreement of one person to accept the actions of another on their behalf.	
	3.2 Consent must be voluntary, and given by one who is competent to choose and is fully informed of the implications of that choice.	
	3.3 When a resident does not have the capacity to choose, there are mechanisms and laws that dictate who is appropriate to choose for the resident, such as through living wills, health care proxy/surrogate, power of attorney for healthcare decisions.	
<p>Examples useful here – seek input</p>	4.0 Confidentiality is a critical ethical issue with professional-resident relationships. Healthcare providers are involved in very intimate, private relationships with residents and families at the end of their lives. Residents and families have the right to expect their experiences and decisions are kept confidential.	Slide 9
	4.1 End of life care often involves personal communications, final confessions, and conversations about forgiveness and guilt. Therefore residents must feel comfortable in a healthcare provider’s trust and confidence to be fully supported as they work through these issues.	
	4.2 New federal HIPAA (Health Insurance Portability Accountability Act) laws will mandate even tighter controls to protect resident health information. Healthcare providers must know their individual agency policies.	

Teaching Cues	Content	Resources
<p>“Disclosure”</p> <p>Very difficult issue, must consult with team and supervisor.</p>	<p>5.0 Disclosure involves revealing information about the resident’s illness, and the resident and family adaptation to this time in their lives.</p>	<p>Slide 10</p>
	<p>5.1 In previous years there was a belief that not telling residents and/or families bad news was better for them. Research and clinical practice has shown that care is generally improved by open and honest communication. Healthcare providers must therefore be comfortable and skillful in communication at the end of life.</p>	
	<p>5.2 Without knowledge of their disease process and prognosis we rob residents and families of the opportunity for growth in this time of suffering and the ability to make informed choices</p>	
	<p>5.3 Sometimes a family will request that the resident not be told the nature of his/her illness and prognosis. Such a request should be carefully and sensitively discussed to determine the reason behind the request and possible consequences of not telling.</p>	
	<p>5.4 The Right Not to Know - Residents also have a right to decline information or to not know.</p>	
<p>These four concepts frame values underlying issues of ethical treatment.</p>	<p>6.0 Four major principals of Medical Ethics may be useful to review in discussion about topics that pose challenges to residents, families and healthcare providers.</p>	<p>Slide 11</p>

Teaching Cues	Content	Resources
	6.1 BENEFICENCE. Is synonymous with the Hippocratic obligation to act always in the best interests of the patient. It is grounded in the concept of promoting the resident's well-being. The relief of pain is one of the best examples.	Slide 11
	6.2 AUTONOMY, or patient self-determination, recognizes the right of a patient with decision-making capacity to make decisions about treatments according to his/her own beliefs, cultural and personal values, and life plan. This is true even when those decisions differ from what has been advised or recommended by a clinician.	Slide 12
	6.3 NON-MALEFICENCE is synonymous with the Hippocratic obligation to avoid doing harm to a patient. Non-maleficence obligates respect for the inherent worth and dignity of every resident and the avoidance of treatments and interventions that do them harm. An example would be many medications and treatments will ease suffering but cause unwanted side effects. Decisions on symptom control must consider providing benefit while minimizing harm.	Slide 13
	6.4 JUSTICE, the fair allocation of resources, is the principle most remote from traditional medical ethics. A clinician's first obligation is to the patient, but, as the costs of providing care continue to rise, society cannot be expected to pay for futile treatments. Neither society nor healthcare providers are obligated to provide treatments that offer no reasonable expectation of benefit.	Slide 14

Teaching Cues	Content	Resources
Definition of “Quality of Life” is very broad and individual.	7.0 Prolongation of life and quality of life Acute therapeutic care--An ethical dilemma that may arise is whether or not a resident should be treated for a secondary problem, such as an infection, if death is pending. Pneumonia has historically been considered "an old person's friend". For example, antibiotic therapy may clear up an infection, but it may also prolong the life of a suffering resident.	Slide 15
Important to set parameters or outcome measures and communicate with team.	8.0 Palliative treatments (e.g. surgical, radiation, chemotherapy)--The surgical placement of a shunt may relieve pressure on the brain and related symptoms, improving quality of life and decreasing suffering for a terminal resident. Similarly chemotherapy and radiation could appropriately be considered for palliative goals.	Slide 15
	8.1 It is also important to offer time limited trials wherein residents try potentially beneficial treatments for a short term then are provided an opportunity to reconsider options.	
More common with accidents, sudden onset, or children	9.0 Artificial life-supporting procedures—Artificial life support may, in some cases, be very appropriate to relieve symptoms, but in other cases, it may be seen as prolonging suffering of a resident who is dying.	Slide 16 Handout II
	9.1 We must also be aware of not only the physical benefits of life-support but the psychosocial benefits for both the patient and family	

Teaching Cues	Content	Resources
<p>Hard Choices – Use with families</p> <p>Common misconception about hospice care – not required.</p>	<p>9.2 Life-support procedures may allow time for the resident/family to become prepared and able to say their good-byes before a resident dies, or for a resident to get their affairs in order, to complete the emotional and spiritual tasks of dying</p> <p>9.3 Resuscitation - The resident or their surrogate has the right to either accept or refuse resuscitation. Access to quality end-of-life care should never be dependent on a resident’s status for resuscitation</p>	<p>Slide 16</p>
<p>Withhold and withdraw ethically the same</p>	<p>10.0 Withholding and/or withdrawing of treatment While prolongation of life poses complex issues, the withholding and/or withdrawing of treatment poses even more complex ethical questions.</p> <p>10.1 When a patient or surrogate decides that a proposed treatment will impose undue burdens, the resident or the surrogate should be entitled to refuse initiation of the treatments, based on the resident’s right to self-determination.</p> <p>10.2 Similarly, when a resident or surrogate in collaboration with the responsible healthcare provider decides that a treatment has become more burdensome than beneficial to the resident, it is appropriate to withdraw that care.</p>	<p>Slide 17</p>
<p>Need to learn and know values and beliefs. Supervisor must know impact of staff beliefs.</p>	<p>10.3 Health care professionals may find it difficult to stop life-sustaining treatment because they have been trained to do everything possible to support life. Stopping such treatment may seem to be unethical practice.</p>	

Teaching Cues	Content	Resources
	10.4 Common situations of the withholding or withdrawal of treatment include: withholding or withdrawing of artificial feeding, hydration, ventilation; cardiopulmonary resuscitation, dialysis, antibiotic use and turning off pacemakers. .	Handout III
	10.5 Withdrawal or withholding treatment is a decision/action that allows the disease to progress on its natural course. It is not a decision/action intended to cause death	
	11.0 Do Not Attempt Resuscitation/No Code orders	Slide 18 Handout IV
	11.1 Do Not Attempt Resuscitate (DNR) form confirms and expresses that no measure be carried out to artificially prolong life such as cardiopulmonary resuscitation and related advance life support systems.	
Know your agency policy and paperwork	11.2 Michigan requires a written order from a physician depending on the setting of care of the resident. Homecare residents who object to CPR on religious grounds are not required to have a physician's signature.	
Incorrect public perception	11.3 Not required by standards or law for admission to hospice programs.	
Legislation driven recently by ambulance companies	11.4 May be required for emergency medical response systems in order to not resuscitate.	

Teaching Cues	Content	Resources
	<p>12.0 Medical futility.</p> <p>12.1 There are times when there are conflicts regarding belief of the beneficial nature of a treatment. These situations are referred to as "medical futility" and are common reasons for ethics consults or ethics committee presentations.</p> <p>12.2 These conflicts often involve failure in communication or mis-understandings over prognosis or benefits versus burden of treatment options.</p> <p>12.3 There are also important cultural and religious influences in these matters.</p> <p>12.4 By asking the fundamental question, "Who are we doing this for?", many futile interventions can be avoided. The answer should be guided by the patient's values. Often, interventions (e.g. daily weights, mobilizing residents, continuing dietary supplements) may become questions to involving futility.</p>	Slide 19
<p>Definitions</p> <p>Both against the law.</p> <p>Punishment may be different</p>	<p>13.0 Assisted suicide or euthanasia</p> <p>13.1 In any discussion of physician assisted suicide (PAS) or euthanasia, it is important that the terminology be clear. <u>Euthanasia</u> is defined as an act by which the causative agent in the death of a resident is administered directly by another.</p> <p>13.2 A new pathological state is created, for example when a resident is injected with a lethal dose of medication with the intention of causing the resident's death</p>	Slide 20

Teaching Cues	Content	Resources
Kervorkian effect significant in Michigan	13.3_ <u>Assisted suicide</u> refers to a practice whereby a person other than the resident provides a substance (usually a medication) to a resident with the intent that the resident will use the medication to commit suicide. This "other" does not administer the drug, but provides the means for a resident to voluntarily end his/her own life. .	Slide 20
Response to PAS	13.4 In contrast to the PAS debate, the right to palliative care is uniformly acknowledged. The same US Supreme Court decision supported the right of all Americans to receive quality palliative care. .	
Tailor to audience, professional vs. non- professional. Use team, don't keep secrets.	<p>14.0 Healthcare providers have the responsibility to respond to requests for hastened death in a way that supports the needs and expectations of the resident while offering care that is both ethical and legal.</p> <p>14.1 Trained professional clinical staff must provide realistic alternatives which, requires a working knowledge of palliative care interventions, including aggressive symptom control and supportive care.</p> <p>14.2 Interventions can often be most effective when the clinician collaborates with other members of the interdisciplinary team.</p> <p>14.3 There is growing opinion that residents' access to optimal symptom control and supportive care would address the suffering of most residents with life-threatening illness and eliminate their desire for hastened death.</p>	Slide 21

<b>Teaching Cues</b>	<b>Content</b>	<b>Resources</b>
Focus on professional staff	14.4 A request for PAS is often a sign of resident crisis where unmet needs have built up and result in this plea for help. For all residents, the request for PAS should prompt an assessment of reasons for the request.	Slide 21
	14.5 Residents make requests for many different reasons that usually arise from physical, psychological, social or spiritual suffering or practical concerns.	
	14.6 For some residents, this request is their first expression of unrelieved suffering.	
Focus on professional staff	14.7 The American Nurses Association has based its position statement on assisted suicide from the philosophical stance of respect for residents that is extensively explicated in the Code for Nurses with Interpretive Statements. Their position statement maintains that nursing may not deliberately act to terminate the life of any person, that it has a social contract with society that is based on trust. It further states that while the nursing profession and its individual practitioners are committed to the resident's right to self-determination, nurses are not obligated to comply with all requests.	
New Topic	15.0 Provision of palliative care When should palliative care begin? Palliative care can actually begin from the time of diagnosis and be applied aggressively to assure comfort throughout the course of an illness.	Slide 22

Teaching Cues	Content	Resources
Definitions “palliative and “curative”	15.1 Treatment falls into two major groups, “curative” is aimed at keeping a person alive as long as possible by curing disease.	Slide 22
	15.2 “Palliative” is aimed at keeping a patient comfortable, rather than curing the disease or extending life.	
	15.3 Some disease processes, such as cancer, allow for more definitive lines between curative and palliative approaches. Other disease processes are appropriate for palliative care from the time of diagnosis such as congestive heart failure or chronic obstructive pulmonary disease.	
	15.4 Palliative care can enhance quality of life throughout the course of an illness as residents and families adapt to the changes brought about by the disease progression.	
Law and practice differ, use material available to educate	16.0 Michigan Public Act 594 of 1996 required physicians to inform terminally ill residents about the option of hospice care	Slide 23
	17.0 Control of symptoms The preventing and relieving of suffering and provision of comfort to both the resident and their family are essential as they adapt to advancing illness and end-of-life issues.	Slide 24
	17.1 It is imperative that the health care professional understands the goals of comfort care versus curative care.	
	17.2 Symptom management supports a holistic approach of physical, psychological, social, and spiritual care.	

Teaching Cues	Content	Resources
Still difficult to overcome in many nursing homes. “nonmaleficence”	<p>18.0 Principle of double effect The issue of double effect involves taking an action, intended to have a good effect, with a known harmful effect.</p>	Slide 25 Handout V
	<p>18.1 Clinical staff should not hesitate to use full and effective doses of pain medication for the proper management of pain in the dying resident.</p>	
	<p>18.2 The increasing titration of medication to achieve adequate symptom control, even if hastening death secondarily, is ethically justified</p>	
	<p>19.0 Cost of end-of-life care</p>	Slide 26
	<p>19.1 The rising costs associated with health care in our country have created many ethical dilemmas. Hospice care is a cost effective option of care.</p>	
	<p>19.2 Providing futile treatment and procedures certainly adds to this ethical discussion.</p>	
	<p>19.3 Quality end-of-life care is a right for all people, yet there are serious limitations in reimbursement.</p>	
	<p>19.4 The financial burden of care-giving in the home and/or need for placement of residents in nursing homes is largely shouldered by families. The survivors of these families are often drained of any future financial stability.</p>	

Teaching Cues	Content	Resources
<p>Introduce Hospice care geared toward end of life; experts in palliation. There is a desire to partner with other health-care providers</p>	20.0 Hospice Care	<p>Slide 27 Handout VI</p>
	20.1 All residents at the end of life have the right to alert, pain-controlled lives. Hospice is an option that all healthcare providers should be familiar with. What exactly is Hospice?	
	20.2 Hospice is a special kind of care designed for someone living with a terminal illness.	
	20.3 This type of care focuses on the resident’s family as well as the resident.	
	20.4 Central to the concept of hospice is the belief in resident family choice related to treatment decision and the plan of care.	
	20.5 It is based on an interdisciplinary approach to care for the dying and emphasizes relief of suffering in physical, psychological, social and spiritual realms.	
	20.6 Beyond relief of suffering are the goals of enhanced dignity and quality of life.	
<p>Most eligible patients never get a referral.</p>	21.0 Hospice is available in every county in Michigan.	<p>Slide 28</p>
	21.1 To be eligible, a resident must have a life expectancy of six month or less if the disease runs its normal course, a condition certified by the resident’s physician.	
	21.2 Hospice care must be freely chosen or “elected.”	
	22.0 Hospice care covers all treatments, medications, supplies, equipment, medications, counseling, therapies, and service related to the terminal illness, including full coordination of care across treatment sites or levels of care.	<p>Slide 29</p>

Teaching Cues	Content	Resources
Wide range of benefits – full service	22.1 Hospice team members include physicians, nurses, social workers, spiritual counselors, home health aides, therapists, volunteers and bereavement counselors.	Slide 29
Bereavement Support	23.0 Hospice programs offer bereavement services to family members for up to 13 months after the death, and include information, support and assistance coping.	Slide 30
Crosses care settings and service intensity	23.0 Hospice is provided at four “levels of care.”	Slide 31
	23.1 Routine care is provided to a resident in their place of residence, including an extended care facility or adult foster care home. Resident and family (including paid staff from the residence) are able to manage the care with assistance from the hospice team.	
	23.2 Continuous care is a skilled nursing service provided in the resident’s place of residence, designed to manage a crisis.	
	23.3 Inpatient care is provided in a facility for symptoms or crises that cannot be managed at home.	
	23.4 Respite care is provide in a facility, designed to give family members a rest from resident care, perhaps allowing them to attend a family event, or take a needed break.	
	24.0 Both Medicare and Medicaid provide a hospice benefit, as well as many other types of health plans.	Slide 32
	24.1 Hospices can help people determine coverage and benefits, and some hospices provide care regardless of a resident’s ability to pay.	

Teaching Cues	Content	Resources
Mistake is “only cancer diagnosis”	25.0 Diseases that are cared for in hospice include, but are not limited to: cancer, pulmonary disease (chronic bronchitis, chronic obstructive disease, emphysema, and fibrosis) heart disease (such as congestive heart failure, heart attacks, and hardening of the arteries to the heart), kidney failure, AIDS, multiple sclerosis, peripheral vascular disease, amyotrophic lateral sclerosis (Lou Gehrig’s disease), Alzheimer’s disease, dementia, liver disease, coma, and co-morbid conditions that may result in failure to thrive.	Slide 33
Topic – How to do it  Tie to specific agency structure and policies	<p>26.0 FACILITATING ETHICAL &amp; LEGAL PRACTICE Ethical issues are inevitable in end of life care and represent complex, often unsolvable dilemmas.</p> <p>26.1 Many conflicts can be prevented and most which occur can be best resolved through a foundation of ethical practice.</p> <p>26.2 Code of Organizational Ethics In order to help guide staff and volunteers as to what constitutes appropriate ethical behavior under different situations, organizations should adopt policies and procedures related to end-of-life care.</p>	Slide 34
Tailor to audience, omit if no involvement	27.0 Advance care planning Advance care planning is a process of decision making and the communication of those decisions between the person and their family, friends, physicians and other health care providers that ensures that resident’s choices are known, preferably long before a crisis situation or when they can no longer communicate their wishes.	Slide 35

Teaching Cues	Content	Resources
	27.1 The process helps residents identify and clarify their personal values and goals about health, medical treatment, and how, where, and with whom they want to live the end of their lives and puts in place concrete arrangements for services.	Slide 35
	27.2 Advance care planning is the process of planning for future medical care, particularly for the event when the resident is unable to make his or her own decisions.	
	27.3 It also involves the resident deciding and designating whom they would like to make those decisions on their behalf in the event they cannot.	
	27.4 When residents communicate these wishes ahead of time, it decreases the chance of conflict in future decision making, decreases the potential for ethical dilemmas, and takes the burden of the family and healthcare team when the resident can no longer communicate for themselves.	
	27.5 The sense of control and peace of mind that this process fosters in the resident and the reduction in anxiety of proxy decision makers are important benefits.	
	27.6 There are legitimate cultural, ethnic, and age related differences in approaches to medical decision making and advance care planning.	
	27.7 However, generalizations should not be made and it is important to determine how each resident and family want medical information to be shared and decisions made early in the therapeutic relationship.	

Teaching Cues	Content	Resources
<p>Define term</p> <p>Ask how many in audience have their own</p>	<p>28.0 <b>Advance Directives</b> describe a variety of methods that allow an individual to direct his or her care and decisions in the event that they become unable to communicate. A person may fill out a form, or name a spokesperson to <i>direct</i> care in <i>advance</i> of illness or injury.</p>	<p>Slide 36 Handout VII</p>
	<p>28.1 There are a variety of documents and situations that come under the general category of advance directives in health care.</p>	
	<p>28.2 Health care is only one area that an individual may designate this type of directive; the other major area is business and finance.</p>	
	<p>28.3 Conservators, executors and trustees often represent people's money matters.</p>	
	<p>28.4 Some categories of spokesperson may cover an individual's rights in both matters of business and health, occasionally Powers of Attorney or Guardians have broad powers.</p>	
	<p>28.5 Some families may need guidance in navigating personal or household finances when terminal illness disrupts normal routine affairs. It is best to make a social work referral in these cases, and often families will need to seek formal legal assistance.</p>	
<p>Define term</p>	<p>29.0 <b>Living Wills</b> are documents that spell out a person's desires for treatment, care and interventions.</p>	<p>Slide 36</p>

Teaching Cues	Content	Resources
	<p>29.1 They only come into effect when one is terminally ill or permanently unconscious or minimally conscious due to brain damage and will never regain the ability to make decisions.</p> <p>29.2 There are many forms available, and this document is NOT legally binding in Michigan.</p> <p>29.3 This document does not provide for a spokesperson or resident advocate.</p> <p>29.4 There is disagreement among experts on whether a person should complete both a living will and a power of attorney for health care. Those in favor state that it increases a person's chance to receive the treatment they desire, and directs the patient advocate. Those opposed to completing both documents feel that specific instructions in a living will may serve to constrict a patient advocate involved in a series of decision in a complicated medical situation unforeseen by the resident..</p>	Slide 36
	<p>30.0 <b>Power of Attorney</b> documents, in several variations below, are those that name an advocate to speak for an individual. Unlike living wills, they may cover business issues, health issues or both.</p> <p>30.1 Power of Attorney is usually used to allow a person who is physically and mentally able to make their own decisions to give that right to another to complete business when they are prevented from doing so due to time or distance. One person <i>gives</i> power to another person.</p>	Slide 36

Teaching Cues	Content	Resources
	30.2 Durable Power of Attorney is a document that allows an advocate to act on behalf of another person when that person becomes unable to act due to physical or mental changes. This is a general document and usually is written to cover both business and health care issues.	Slide 36
Forms and process is simple – know resources	31.0 Durable Power of Attorney for Health Care/Medical Durable Power of Attorney is a document that allows a patient advocate to act in health matters when a patient becomes unable to act	Slide 36
	31.1 The law requires that two physicians, or a physician and a licensed psychologist document that a resident is unable to act on their own behalf.	
	31.2 A new law in Michigan formally allows Patient Advocates for Health Care to elect hospice care for a resident.	
	32.0 Who can make treatment decisions for someone else? Patient Advocate is the person who accepts the responsibility outlined in the Power of Attorney situation.	Slide 37
	32.1 This person must be designated in writing, and must accept that responsibility in writing. This person may also be referred to as “patient surrogate,” “proxy,” “attorney-in-fact.”	
	32.2 He or she must be at least 18 years old, is required to act on the resident’s behalf, and can only make decisions that the resident could make if not otherwise incapacitated.	

Teaching Cues	Content	Resources
<p>Technical detail, skip if audience is not involved in this aspect</p>	<p>32.3 Who cannot complete Advance Directives? A good example of a person who cannot complete an advance directive is one who is not conscious, a child, or a person who is mentally “incompetent” due to disease, drugs or developmental disability.</p>	<p>Slide 37</p>
	<p>32.4 These people cannot freely give or bestow their right to make treatment decisions to anybody, but in some cases the law provides for a spokesperson.</p>	
	<p>32.5 In the case of a minor child, a parent is considered a legal guardian, and can make decisions.</p>	
	<p>32.6 In the case of a developmentally disabled person, or a person who has been ill for a period of time, there is a formal process to appoint a guardian. The process includes a court hearing and judgment, and requires expert proof that a person is unable to act on their own behalf. The courts consider the “ward” a “protected person” and require the guardian to act in their best interest.</p>	
	<p>32.7 Because the laws are specific, there are some things legal guardians cannot do, and one of them is sign a DNR order for people living at home.</p>	

	33.0 Advance directives can take many forms, and laws about directives vary from state.	Slide 38
General intro, covers federal law	33.1 Federal law requires health care agencies to provide information about advance directives to all residents.	Slide 38
	33.2 No law or standard can or should REQUIRE a person to complete any form of advance directive, and laws do prohibit any refusal of treatment or discrimination toward a person who cannot or will not do this.	
	33.3 Laws also require that if advance directives exist, that health agencies make every attempt to find them and follow them.	
Role of professional clinical staff	34.0 WHEN ETHICAL DILEMMAS OCCUR The clinician as advocate	Slide 39
	34.1 It is the professional clinician's responsibility to assure: Resident/family fully understand the options available so they can make informed decisions.	
	34.2 Clarification of resident/family wishes	
	34.3 Communication of resident wishes in collaboration with an interdisciplinary team of caregivers.	
	34.4 The separation of personal values and morals from the resident's and family's decision making process.	

Teaching Cues	Content	Resources
Use agency format or access resources if desired	35.0 Formal case analysis When ethical dilemmas occur that cannot be resolved through the usual care planning and communication processes, it is helpful to apply a case analysis format for reflection. There are various formats for ethical presentation of cases.	Slide 40 Handout VIII
Know agency structure	36.0 Ethics Committee involvement All healthcare institutions should have access to an ethics committee. Often end-of-life issues are addressed by ethics committees.	Slide 41
	36.1 The committee's purpose is to provide a forum for ethical reflection and discussion of values, to build a moral community and attempt to meet the needs of the resident and other affected individuals through group process and consensus.	
	36.2 Ethics committees often validate or provide options regarding ethical dilemmas and support the care team in relation to already planned options.	
All audiences	37.0 CONCLUSION Application of principles of ethics assists in a search for best solutions to complex ethical dilemmas at the end of life.	Slide 42
All audiences	37.1 Ethical process is a way to seek balance in decision making by addressing values and understanding the needs of those involved.	
Advance practice clinical staff only	37.2 Professional clinical staff have a responsibility to residents and families to advocate for their rights to pursue choices and make informed decisions.	

<b>Teaching Cues</b>	<b>Content</b>	<b>Resources</b>
All audiences	37.3 Healthcare providers should work very closely with all disciplines to address ethical issues in end of life care.	Slide 42
Additional material for step by step ethics discussion.	<b>ADDITIONAL RESOURCES</b> Clinical Pragmatism: A case method of moral problem solving	Handout IX
Use either Q & A format or role-play scenario.	Ethical Principles and Practices – Discussion Questions	Handout X