

Responding to Ethical Dilemmas in Nursing Homes: Do We Always Need an “Ethicist”?

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Late one night you are called to the room of an elderly nursing home patient who has been febrile for three days and is now short of breath, coughing, and tachycardic. She has already received three days of oral antibiotics. The patient was treated for pneumonia a year ago in the nursing home and has a history of hypertension and early dementia but has otherwise been healthy. Though mildly confused at times, presently she is alert and oriented and appears to understand her circumstances. Her respiratory status is quickly deteriorating, however. You and the other nursing staff are concerned about impending respiratory failure. There is no Do-Not-Resuscitate order in the chart. You feel hospitalization may improve her chances for survival and that short-term intubation with ventilator support may even be indicated in order to stabilize her medical condition. She has a living will indicating “no life support if terminal conditions” and the patient has recently refused hospitalization, yet her family is telling you that “she really doesn’t mean it” under these circumstances because she is sick and confused and has agreed to being hospitalized before. It’s time to act—what to do?

Making decisions within the complexities of modern health care is not easy. This is especially true in long term care situations where the preferences of often chronically debilitated patients may not be known and for whom hospitalization or other intervention may increase their risk of death, suffering, and further impairment. Ethical dilemmas often present themselves in this context, and having a mechanism available to effectively address complex ethical issues in a timely fashion is critical to the quality and safety of patient care. One of the most common ethical challenges occurs when the patient has questionable capacity to make decisions and it is unclear as to what they would want us to do, and whether the burden of treatment is worth the expected benefit and expense. Not uncommonly in

such circumstances the values and expectations of health care providers, the patient, and family members are in conflict. Other questions relating to health care cost and resource allocation, typically addressed at the organizational level, may also have significant impact at the bedside when patients and families are being directly impacted. When broad ranging questions such as these arise it is important to address them in a consistent and deliberative fashion in order to maximize the satisfaction, understanding, and participation of everyone concerned, and so the best possible clinical outcome can result both medically and morally.

Ethics consultation within health care systems has been encouraged by the courts, endorsed by a major President's Commission, and supported by Joint Commission on Accreditation of Healthcare Organization (JACHO) (Aulisio, 2000). JACHO has required a mechanism to deal with ethical issues since 1992. The function of ethics committees is to provide training and education for itself and others and to provide for organizational policy development in areas of end of life care and other concerns regarding ethical behavior and professionalism. The third and perhaps most important function of ethics committees is facilitation of ethical discussions and case review, which can be either through the committee itself or with a separate clinical ethics consult service. Studies have shown that when ethics consultation is done physicians, patients, and families tend to be satisfied and there are fewer hospital days and life-saving treatment for patients at the end of life (Schneidermann, 2000). Yet, ethics consultants tend to see only a small fraction of the tough ethical cases in health care settings, including nursing homes (Tulsky, 1996). The reasons for this are complex, but typically relate to the effectiveness, accessibility, and affordability of such services both inside and outside systems of health care.

Why is the Long Term Care Question Important?

The ability to effectively address ethical issues, such as care at the end of life, decision making capacity, and issues of privacy in this vulnerable population is becoming increasingly important as greater demands will be placed on the health care system in the years to come resulting from an expanding and aging demographic. In 1995 “only” about 0.6% of the U.S. population, 1.5 million people, lived in 16,700 nursing homes, in which 1.8 million beds that were maintained at 87% capacity (Gabrel, 2000). By 2030 this number will have increased to 5 million (Zedlewski, 1989; Doty, 1992). Some 90% of nursing home residents are over the age of 65; most are female and white. Most nursing home residents are debilitated, have a difficult time representing themselves autonomously, and need assistance with activities of

daily living and instrumental activities of daily living. A sobering estimation is that nearly half of the people over the age of 65 will one day enter a nursing home, half of which will stay at least a year and 21% will stay at least 5 years (Kemper, 1991). Perhaps most compelling is that 20% of U.S. deaths occur in nursing homes; end of life decisions are the most common situation resulting in ethical and moral conflict in nursing homes (Ersek, 2003).

The expanding elderly population is also becoming more elderly. By 2030 close to 20% of our population will be over the age of 65, which means that this demographic will have doubled from 30 to 60 million people and the population over the age of 85, which is the fastest growing demographic in our country, will also double from 3 to 6 million. Life expectancy is 10 years at age 65 and 5 years at age 85. Even more concerning is that 40% of those over the age of 85 still living in the community have dementia, which dramatically increases their risk for ultimately needing care in a structured environment, and the need to have a means by which to represent their interest when questions arise about treatment (Ouslander, 1997).

Evolving ethnic and cultural differences in the nursing home population is also becoming an increasingly important concern. Though the overall proportion of older people staying in nursing homes has fallen by 8% in recent years, the U.S. Census Bureau indicates that the proportion of black residents has increased while that of whites has decreased (U.S. Bureau of the Census, 2005). In 2003, 3.7 million people (11% of the older population) were foreign born, most from Europe and Latin America (35% each) and Asia (23%). In 2000, 13% of the older population spoke a language other than English at home, among them one-third spoke Spanish. The Census Bureau projects that by 2030 the ethnic composition of the older population will have shifted to where 72% will be White, 11% Hispanic, 10% Black, and 5% Asian. This is compared to 83%, 3%, 8%, and 6% respectively in 2003. How chronic disease and dysfunction are interpreted and manifest in each of these groups, and the cultural mores that inform the response that patients and families will have to these health concerns, will be increasingly important considerations for providers and ethics consultants who are called upon to deal with the conflicts and miscommunication that often occur during the stress of aging and increasing debility.

The fiscal note in this argument is that nursing home care is the fastest growing health care expense in the national budget. In 1990, long term care cost \$53 billion in this country and by 2000 it was up to \$140 billion. By 2030, long term care is estimated collectively to cost over \$700 billion in this country (Levit, 1991). Long term care, as an economic behemoth for society, also translates into significant personal financial burdens closer to

home. Medicare covers long term care costs but only for short periods and through limited use of skilled care. State Medicaid programs covered only 44% of nursing home expenses in 1998 while providing for two-thirds of all nursing home residents (Feder, 2000). But these programs have limits. Out of pocket spending is needed to cover more than a quarter of long term care costs, which averages more than \$40,000 annually for severely impaired residents (those having lost three or more activities of daily living). This inflicts a significant and often insurmountable financial burden for many patients and families. Because the need, use, and costs of nursing home care are booming, efforts to improve that care, optimize appropriate treatment, and promote ethical decision making are increasingly important.

Ethical Issues Unique to Long Term Care

Questions concerning decision making capacity and end of life treatment decisions are the most common ethical dilemmas confronting patients, families, and providers in the long term care setting. The majority of patients in nursing homes are older than 65 (over 90%) and over half of those have dementia; residents who are non-white, married, and with fewer years of education are more likely to be demented with the prevalence of dementia also being highest among those with greater physical impairment (Magaziner, 2000). These individuals are particularly vulnerable and the ability to exert control over their situation and make rational choices regarding treatment and other aspects of their life is markedly limited. The autonomy of residents in nursing homes is negatively impacted by functional impairment, loss of decision making capacity, and increasing dependency. This often means that decisions regarding treatment are left to family members and providers who may not have a clear idea as to the preferences of the patient. Decisions whether to hospitalize and aggressively treat are further complicated by limited access to specialty services and other supportive technologies in the long term care setting. Conflict often arises, therefore, when patients become acutely ill, their prognosis is not clear, and there is no clear direction as to how aggressive to be with treatment.

The Patient Self Determination Act (PSDA) in 1991, requiring all federally funded health care facilities to encourage and inquire about health care directives for patients being admitted to their system of care, has generated considerable debate regarding the utility of advance directives, but has had only a modest impact as it relates to patient outcomes (Lynn, 1993). A study of 270 long term care facilities in 10 states found that between 1990 and 1993 documentation of living wills had increased from 4% to 13% in nursing homes, and do-not-resuscitate (DNR) orders were written for 50% of

residents; however, orders not to hospitalize (DNH) and to forgo artificial hydration and nutrition remained less than 8%, having not been impacted by the new requirement of the PSDA (Teno, 1997). Physician Orders for Life-Sustaining Treatment (POLST), a comprehensive one-page order form, was developed to convey preferences for life-sustaining treatments during transfer from one care site to another. POLST was designed to ensure that nursing home residents' wishes were honored regarding attempting resuscitation and requests for transfer only if comfort measures fail. A recent study in Oregon found that POLST orders regarding CPR in nursing home residents were universally respected, and that patients received remarkably high levels of comfort care and low rates of transfer for aggressive life-extending treatments (Tolle, 1998). Questions of futility, withholding and withdrawing treatment, and substituted judgment as to patient preferences are common questions that arise when dealing with ethical conflicts at the end of life in long term care facilities.

Implementing palliative care at the appropriate time is also a problem. Nursing homes are the site of death for many patients with incurable chronic illness; yet dying nursing home residents have limited access to palliative care and hospice. The probability that a nursing home will be the site of death increased modestly from 18.7% in 1986 to 20.0% by 1993 (Zerzan, 2000). Patients at the end of life still tend to have high rates of untreated pain and other symptoms. Unfortunately, current quality standards and reimbursement incentives still tend to encourage restorative care and technologically intensive treatments rather than labor-intensive and thus costly on site palliative care services. In 1997, only 13% of hospice patients were in a nursing home while 87% were in private homes—70% of nursing homes had no patients in hospice (Zerzan, 2000).

Psychosocial concerns regarding loss of privacy, feelings of social and spiritual isolation, and limited availability of family and friends often create crisis situations for nursing home residents as well. Depression continues to be a major clinical concern for nursing home patients that can often go unnoticed, yet may have a major impact on decision making capacity, and the ability to communicate effectively. In one study, major depression was found in 12%-25% and minor depression in 18%-30% of residents when screened, and was found to increase the likelihood of death by 59% independent of other risk factors (Rovner, 1991). The psychosocial components of a patient's life, including family dynamics, spiritual needs, and the patient's sense of dignity are important variables to consider when addressing ethical questions in the long term care setting.

Availability of Ethics Expertise in Nursing Homes

The American Society of Bioethics and Humanities (ASBH) has put forth a rather detailed set of core competencies for doing health care ethics consultation, the goals of consultation being to improve the provision of health care, to identify and analyze the nature of the conflict, to facilitate resolution of these conflicts, to inform institutional policy, and to provide education (1998). Ensuring that ethics consultants have the skills and knowledge expected and needed to do the job responds to only part of the problem, however. The challenge for clinical ethicists will be whether their expertise and service will be transferable and available to those who need it outside of large centralized academic and private health care centers and in the more remote areas where nursing homes exist and where ethical dilemmas will increasingly occur.

In 1991, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) mandated all licensed hospital and nursing homes to establish a “mechanism” to consider ethical issues in patient care and to educate health care professionals and patients in these issues (JCAHO, 1992). Though nursing homes may have ethics committees at least in policy, committee members are often not ethics trained nor do they have trained ethicists available for on site consultation due to cost and budgetary constraints. Clinical ethicists, for the most part, are housed in large urban academic and private medical centers where they work and deal specifically with the ethical concerns of their own institutions. Though ethicists may provide education and training on and off site, it is unusual for them to provide formal consultation resulting in documentation in the medical record of patients in long term care facilities. Ethics consultation, when it does occur off site, is typically informal and by phone. Unfortunately, deliberation about the ethical concerns of nursing home patients often occurs in times of crisis and after the patient has been transferred to the hospital, and only then when the ethical issue is identified and felt to warrant discussion by the patient, their family, or the treating team. This means that many of the critical issues related to futility, respecting patients’ wishes to limit treatment, not transferring to acute care facilities, and maximizing comfort measures in place may not be dealt with prior to transfer when such considerations and requests can most effectively and collectively be addressed by those closest to the patient—the patient’s physician, nursing home staff, and family.

Though infrequent, there are ethics consultation services that provide off site formal ethics consultation through novel means such as tele-ethics video conferencing, telephone conferencing, and electronically through email (MU Center for Health Ethics, 2006). These interventions, provided by

academically trained ethicists, follow the same rigorous standards of method and documentation as those on site in the tertiary care system in which the ethics consult service functions. The outcomes and general satisfaction resulting from these services have anecdotally been found to be very positive, though a more rigorous evaluation is needed to determine the true benefit and utility that off site ethics consultation is having for the long term care facilities being served in this way. The overall penetration is still felt to be low, however, even when using these novel ways of reaching out to remote areas that need help. The Office for the Advancement of Telehealth, an office of the U.S. Department of Health Resources Services Administration, lists only 19 nursing homes being served by well over 100 telehealth systems networking all 50 states (Health Resources Services Administration, 2006).

Though awareness and need are growing, nursing homes often times do not have usable mechanisms in place to effectively deal with complex ethical dilemmas on site due to budgetary constraints, the challenges of understaffing, and the necessary reliance on providers with often limited training and education. The ASBH and others have expressed legitimate concern as to the variable levels of training, competency, and consistency by which clinical ethics consultation is provided, challenging the professional health care community to consider standards of performance, certification, and even licensure for those purporting to be clinical ethicists (ASBH, 1998; Fletcher, 1994; Ross, 1994). These concerns are not unreasonable when recognizing the variability of background and training that exists in those who offer themselves as “ethicists”. Presently there are no unified standards of clinical ethics education, training, or practice. However, standardized guidelines for ethical reasoning can be provided and are much needed for providers in remote areas when considering the widening gap that is occurring between the availability of trained ethicists and the growing need to have these discussions both in the home care environment and in long term care facilities.

Clinical ethical reasoning is a practical deliberative method and thereby can be learned and is transferable. Because of the unmet needs in long term care, workable guidelines to enable ethical reasoning with an acceptable level of competency should be inserted as a skill set for all providers who care for patients in long term care facilities and other remote areas. This essay provides a pragmatic approach to ethical deliberation that can be learned by providers who may not have received formal training in ethics but who confront ethical issues at the bedside every day. This method will assist providers, managers, and administrators in working through ethical issues with patients and their families when clinical ethicists are not readily

available, either on site, on-line, or via teleconferencing.

Ethical Reasoning in the Nursing Home

The ability to accurately identify and then effectively address ethical dilemmas when they arise is essential to the welfare of residents in long term care facilities who are typically vulnerable and often unable to autonomously represent themselves. The emphasis in ethical reasoning is to provide a cogent and rational progression from the facts of the situation to a morally sound decision. The general framework of ethical decision-making offered by Pellegrino provides the infrastructure of an *ethics workup* that may be used by a variety of health care professionals at both the organizational and the individual level (2000). The framework of ethical reasoning offered is transferable to those not formally trained in ethics and therefore cost effective and available to everyone when needed.

Health care executives, physicians, nurses, social workers, chaplains, and other health professionals may use this or similar techniques to assess ethical dilemmas with the goal of gaining a shared sense of what is morally acceptable. With some adjustment it may also be used by lay persons. By asking three practical questions health care professionals, family members, and other stakeholders, often grounded by different moral or religious beliefs, can share a basic framework for thinking about and discussing morally troubling cases. The goal is to find moral agreement in the midst of differing moral beliefs and traditions, all of which must be respected and considered. Three practical ethical questions begin the dialogue: 1) Who decides? 2) What criteria will be used to make the decision? 3) How can conflict be identified and resolved? In response five pragmatic and sequential steps can then be taken to reach an ethical conclusion (Pellegrino, 1989).

First, it is always important to *clarify the facts* of any situation in order to anchor a decision. These facts relate to the organizational, medical, and social circumstances of the case. Both an estimate of prognosis and an understanding of the patient's wishes are relevant to any ethical decision about what is in the patient's best interest. Resource allocation, though ethically relevant at the organizational level, should be subsidiary to the needs of the patient at the bedside. Most importantly, the facts relevant to ethical decision making pertain to more than medical facts alone, and must include aspects of the patient's life that are important in considering the "good" of that patient beyond what might be considered the medically "right" decision. This includes information about the personal values and beliefs, the degree of suffering, and the spiritual and psychological goals that

are important to the patient.

Other factors to consider are other persons involved or affected; the diagnosis, prognosis, and therapeutic options; clear and convincing evidence in the form of written or verbal statements (health care directives) reflecting the patient's personal preferences, beliefs, and values; the chronology of events; time, technological, and geographic constraints; the medical setting; the organization's mission and policy; and the patient's goals of care and treatment as set out by their statements. Clear and effective communication with the patient and family as well as amongst the team regarding the facts of the case is crucial. Nurses, chaplains, and social workers may be instrumental in ensuring that the patient, family, and other health care professionals understand the medical facts while also making sure that the health care team understands pertinent information about the patient and the family. Administrators and managers also have legitimate concerns for the welfare of the organization, the staff, and the patients the organization serves. Though often important, the organization cannot ethically insert its needs before those of the patient unless the mission and service orientation of the organization are at risk, and thus the welfare of many others for whom the organization is responsible. Even then, the needs and welfare of the patient at hand should be foremost in the minds of providers.

Second, clearly *identify that there is an ethical concern* and what it is; there may be more than one. Ethical claims are often competing, such as the preferences and welfare of one patient vs. that of many when considering resource allocation. The question being posed may not be ethical at all, but rather a legal issue, a utilization concern (such as a placement issue), or simple miscommunication about the clinical facts. Common ethical concerns in the nursing home setting include questions of decision making capacity; the patient's right to refuse or demand treatment; end of life questions regarding futility and the withholding or withdrawing of treatment; appropriate surrogacy and substituted judgment; organizational limitations regarding mission and services available; and policies and practices regarding privacy and confidentiality. In many circumstances, breakdown in communication has resulted in misunderstanding and conflict and simply facilitating open, respectful, and effective communication between parties is effective in resolving disagreement or what may seem to be an ethical concern.

Third, *frame the issue* so that it can be critically discussed through a means of ethical deliberation, using an understandably clear language of ethics that can be shared and understood by everyone participating in the discussion. Some may ground their argument with moral justification (e.g., personal belief, faith, professional oath, medical tradition, etc.). Others will

not be confined to a single source of moral belief but employ one or more ethical arguments grounded in principle or moral theory (good of the patient, principles, good of society, economics, etc.). There being multiple sources of individual moral belief, the ethical issues of the case are likely to be argued differently and thus be in conflict. It is, therefore, useful to dissect the case along lines of two key questions.

Who decides? Respect for autonomy requires the team to identify the appropriate decision maker(s) for *this* patient, which is to say those persons who have a legitimate moral claim of surrogacy if the patient can no longer speak for herself. These may be the patient herself (through verbal or written health care directives), one or more family members (whether or not they are legally assigned as durable powers of attorney), the courts (guardianship assigned), or the health care team and others close to the patient by default if no one else is appropriate or available.

By what criteria? Apply criteria that can be universally agreed upon in reaching a clinical decision. These criteria generally apply to the good of the patient derived along a hierarchal scheme of priority, again as argued by Pellegrino (1988).

1. What is the *biomedical good* of the patient? This is an evidence based determination by physicians and other health care providers based on experience, training, and other evidence as to what the “right” decision is in a particular clinical situation. This process explores the medical options available, their likely outcomes, prognosis, and other decisions in pursuit of preferred and intended medical outcomes. In other words, this is an evidence-based determination as to what *can* be done, not necessarily what *should* be done. Prognosis and likelihood of therapeutic success is a threshold consideration at this level. Treatment options, no matter how “routine”, should be considered only if there is a reasonable chance of reaching their intended outcome; otherwise they should not be offered.

2. What are the broader goods that underscore the *best interests of the patient*? These are patient-centered considerations responding to the patient’s rights of autonomy (the right to be informed and to freely choose or refuse treatment). Dignity, religious faith, other valued beliefs, relationships, and the particular good of the patient as an autonomous person, are all pertinent to the decision at hand. This level of consideration asks what *should* be done, taking into consideration patient preferences, values, and beliefs.

Health care providers should also be attentive to the welfare and interests of others involved in the care of the patient and those who might otherwise be affected by the clinical decisions being made. This is of particular concern when considering the rising cost of health care and the distribution

of resources that may be affected by escalating costs of care for one patient. How decisions affect directly or indirectly the patient's family, other members of the team, the health care organization, and society may influence the decisions that need to be made. When dealing with patient-centered concerns at the bedside, however, these concerns should generally not be given as much importance as the needs of the individual patient to whom health professionals have pledged their service.

Fourth, work to *identify and resolve conflict*. Conflict is common between providers and patients or their families; however, conflict may also occur between providers, or surface as an internal moral conflict of one provider wrestling with questions regarding treatment. During severe illness or the impending loss of a loved one emotions may be heightened and there is often misunderstanding and disagreement. Therefore, it is crucial that there be optimal communication from and among the health care team and that adequate information be shared with the patient and her family. The physician should explain medical options to the patient/surrogates and if indicated make recommendations. The patient or their surrogate should then be supported in making an uncoerced and well informed decision. Recognizing and respecting patients' right to decide based on their own interests, it is also important to recognize that autonomy is not without limits. It is irrational for patients or their family to demand that physicians or other providers exceed the bounds of rational health care; patients do not have the right to intentionally or knowingly harm others; and no one has the right to demand that others serve their needs by violating the bounds of personal or professional conscience. In addition, patient autonomy is not limitless; organizations should not be expected to deviate from their well established mission or allow actions that would make it impossible for the organization to survive financially or structurally. In problematic cases, it may be necessary for the interdisciplinary team to meet and communicate regularly to ensure consistency in their recommendations and plan.

It is important to establish each health care professional's moral position as identified by their personal and professional moral agency within the context of the patient's needs. Each health care professional, both providers and executives, must decide what she/he owes the patient, herself/himself, the health care team, the health care institution, and other third parties. Conflict is unavoidable in a pluralistic society, and typically more than one option will need to be considered for each case. Openness, honesty, transparency of information, and mutual respect are central values that must be shared if there is to also be shared accountability in seeking the best outcome for the patient.

The fifth and final step is to *make a decision*. In health care, decisions

must ultimately be made, which means that someone must ultimately write an order. There is no single or simple formula for making decisions in the midst of conflict but getting to them requires judgment based on facts, practical wisdom, and moral argument. Health care professionals must ask themselves not only what *can* be done but what *should* be done in the context of *that* patient's particular needs and desires. When made, the decision should be a dynamic process taking place over time and through ongoing interaction that takes into consideration new information, the sensitivities of all involved in the care of the patient and, above all, an ongoing exploration of the patient's welfare. Once decided, it is important to continue the dialogue, and periodically reconsider the facts. Just as clinical circumstances are variable and changing, so too are the variables that impact ethical decision making for nothing remains static.

Theories of Ethics and Other Considerations

The answer to moral conflict is found through analysis of the data and moral reflection, and the ultimate decision must be ethically defensible through means of moral justification. Grounding, or drawing from a universal source of ethics, will foster a shared understanding of what "ought" to be done. Grounding theories can be philosophical (based in *reason*), theological (based in *faith*), socio-cultural (based in *custom and tradition*), and based on the nature of the profession. For physicians and nurses, moral obligations are defined by covenantal relationships with patients; for health executives, it is in ethically balancing the interests of one patient with those of many patients, as well as the organization. The compatibility of a recommended course of action must also coincide with the aims of each profession as underscored by the *internal morality* of that profession. Numerous other theoretical approaches to ethical inquiry argue for universal applicability as well. Principles, virtue, casuistry, feminist theory, caring, existentialism, faith, and theological approaches have all been used.

Other ethically relevant considerations in the process of deciding include: balancing the benefits and harms that may result from actions taken; respecting autonomy by ensuring full disclosure, informed consent, and shared decision making; maintaining the professional integrity of health professionals; recognizing the importance of cost effectiveness and prudent resource allocation; being sensitive to cultural and religious variation; promoting health literacy; recognizing and being sensitive to the *power* differential that exists in healing relationships and the resulting innate vulnerability patients; and respecting organizational mission, goals, and needs. All of these considerations are important in the ethical inquiry of

particular cases and must be balanced in accordance with the needs of each patient.

Conclusion

Formal ethics consultation is not readily available in remote areas to advise, facilitate, and assist patients, families, and health care providers to deal with ethical dilemmas and resolve conflict on site. Therefore, creative mechanisms are needed to generalize the ability to have ethics discussions and provide timely assistance for tough cases locally and in remote areas when expertise is not available. This essay offers a clinical ethics methodology for providers in nursing homes based on Pellegrino that can be learned and used by those not formally trained in ethics, and is therefore universally accessible and cost effective. The ability to work through difficult ethical dilemmas will become increasingly important in long term care as our society ages and as this demographic grows in the years to come. The logistics of long term care and the frequent need not to transport patients to acute health care centers due to patient preferences and health risks to the patient underscores this importance. The goal, by whatever means, is to help the patient, family, and team members caring for the patient assess ethical dilemmas and to gain a shared sense of moral acceptability as to what actions should or should not be taken.

In 2001, the Institute of Medicine charged policy makers, health care providers, and organizations in this country to make health care safe, effective, patient-centered, timely, efficient, and equitable (Institute of Medicine, 2001). Ensuring ethics related attitudes, knowledge, and skills in health care providers so they will be well adapted effectively to deliberate the ethical conflicts that will undoubtedly arise continues to be important. Seeking innovative ways to provide ethics expertise to an expanding population of long term care residents, families, and providers who otherwise do not have specialty access, and developing tools to provide distant ethics consultation services in the years to come, such as teleethics video conferencing, will be critical to the success of this mission. When formally trained ethics consultants are not readily available by any means, however, providers from a variety of disciplines can use a deliberative technique, such as the one provided in this essay, that will allow timely discussions through facilitation and a shared dialogue on site.

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