An Application of a Case Study

In Ethical Issues in Nursing Case Management

To the Health Needs of the Undocumented Immigrant Population

By Anthony F. Robertson, RN

New York City College of Technology

NUR 4030 - Case Management: Role and Process

April 25th, 2012

**Concept: Ethical Issues & Dilemmas in Nursing Case Management**

The term “case management” yields different meanings to different people. Several definitions for case management exist in present day; however, when defining the field of case management, two words constantly arise, no matter how case management is defined: Quality, and cost-effectiveness. The aim of case management is to deliver quality care to clients, while simultaneously providing care that controls the costs and potentially unnecessary spending sometimes associated with health care. Even though I have not yet elaborated on the methods by which case managers implement quality to their clients and manage health care costs at the same time, one can see how the aim of case management can set the stage for dilemmas between two or more parties involved in the client’s care.

The case management function of delivering cost-effective care falls under the paradigm of managed care. With managed care, the goal is to encourage consumers, providers, and payors to all become accountable for the wise use of limited and ever-expensive health care resources (Powell & Tahan, 2010). While managed care is a part of case management, it is important to note that they are not interchangeable terms. Managed care is systems-oriented, focusing on health insurance plans and the management of member benefits (Powell & Tahan, 2010), while case management is people-oriented and negotiates the manage care system in a way that, ideally, benefits everyone, particularly the patient (Powell & Tahan, 2010). Nursing case management takes the concept of case management even further by incorporating the holistic, advocacy, and humane care of both clients and their families into their practice (Powell & Tahan, 2010). Situations may arise where the benefit of managing health care costs can interfere with the deliverance of quality client care; in even worse situations, the agenda of cost management can potentially compromise the client and family’s well being. When these situations occur, an ethical dilemma presents itself for the case manager.

Ethical dilemmas can be very difficult to resolve, especially when choosing a decision that benefits one party involved in the dilemma may not benefit the other person (or people) involved, and vice versa. In the face of an ethical dilemma, the nursing case manager struggles to reach the outcome that provides the greatest good to all involved in the client’s care; this is based on an ethical theory called utilitarianism. However, the act that produces the greatest good (also known as act utilitarianism) may not always coincide with the rules that were [supposedly] designed to produce the best outcomes (a concept known as rule utilitarianism). Furthermore, the “best” outcome is not always overt or measurable; sometimes it depends on perspective.

I developed an interest in this nursing case management concept for several reasons. First and foremost, I believe that ethical responsibility is the backbone to all professional practices, including nursing and case management. Based on that truth, I wanted to see how case managers deal with ethical issues that may arise while assessing, planning, and coordinating patient care. Secondly, as a RN, my primary concern is the well being of the patient and family when an ethical issue or dilemma presents itself, as I am their advocate above all else. Nursing case managers are advocates as well, ideally, but they are also advocates for the organization, providers, and payors of health care, in the managed care world of today. Representing both *the* *system* and *the people* simultaneously is much harder than representing one side or the other entirely; this is what sparked my interest in finding out how nursing case managers balance out advocacy to all involved in the client’s care in the face of an ethical issue or dilemma. Finally, I wanted to investigate ways in which culture can affect an ethical issue or dilemma, and how the nurse case manager may go about factoring in culture in his or her ethical decision-making.

**Cultural Competence: Ethics, and the Undocumented Immigrant Population**

Undocumented immigrants are defined as those foreign-born immigrants who do not have the permission or acquiescence of the United States Citizenship and Immigration Services (USCIS) to remain in the United States (Carr, 2006). They may have either a) legally entered the United States by means of visa acquisition, but have violated the terms of their status by over staying their visa expiration, b) entered the country without USCIS documentation (Carr, 2006), or c) by human trafficking. As of March 2010, 11.2 million unauthorized immigrants were living in the United States, with 60% of them residing in the six states of California, Texas, Florida, New York, New Jersey, and Illinois, and 70% originate from Mexico and Central America alone (Passel & Cohn, 2011). Undocumented immigrants are ineligible for government-funded health insurances such as Medicaid, unless they can provide substantial documentation that proves that they have been residing in the United States for at least five years. Health reform acts do not help this population; the Affordable Care act of 2010, for example, excludes undocumented immigrants from all of its programs aimed at helping the uninsured gain coverage (Zuckerman et. al, 2011).

Fear of disclosing immigration status, ineligibility to receive government insurance, and inability to afford private health insurance, are all factors that often cause undocumented immigrants to delay seeking health care. These patients usually present in the emergency department of hospitals when their condition reaches a critical and emergent state. The Emergency Medical Treatment and Active Labor Act (EMTALA) require hospitals to treat patients in emergently unstable conditions, regardless of their ability to pay for health care services. EMTALA regulations only apply when the patient is unstable; however, when the patient is stabilized, EMTALA regulations no longer apply, and the discharge process becomes of primary focus. All hospitals, by law, must coordinate a discharge plan to a level of care appropriate to the patient’s status. This is primarily handled by case management and social worker services. If the patient is stabilized to a point where he or she can independently function after the initial hospitalization, the discharge / transitional planning process is not so difficult. A problem arises, however, when the undocumented patient presents in the emergency department with a debilitating condition, where inpatient hospitalization stabilizes the condition medically, but the condition has rendered the patient medically and functionally dependent, warranting the need for placement to a long term care facility. When this happens, it is extremely hard to place this type of patient in a long-term facility, because the patient has no coverage. The patient ends up staying in the acute inpatient hospital at their expense, which can add up to thousands of dollars in health care expenses. In the landmark legal and ethical case of *Montejo vs. Martin Memorial Center*, such an event took place.

The case of *Montejo vs. Martin Memorial Center* surround the events that occurred to a Guatemalan man who migrated from his country to Florida illegally in order to provide for his family in Guatemala by obtaining work in the United States. Unfortunately, during his stay, he was the victim in a car accident that placed him in critical condition. He was admitted to the hospital and stabilized, but the traumatic brain injury (TBI) he sustained from the accident left him extremely debilitated, and unable to represent his interests. He was transferred to a nursing home under charity care, but then readmitted months later with another emergent condition. Once stabilized, no long-term care facility would accept him because he wasn’t eligible for Medicaid or Medicare. The court appointed the patient’s cousin the authority to make decisions on his behalf, as he was the only family member living in the US. After an inpatient stay of three years, and health care costs of over 1.5 million dollars, the interdisciplinary team at the hospital figured it was cheaper to send the patient to a long term care facility in Guatemala, despite his cousin’s opposition to the action. This is a practice is commonly referred to as medical repatriation; however, those who oppose to this practice commonly refer to it as “patient dumping” (Zoellner, 2010). Although the facility in Guatemala receiving the patient was assessed and determined by case management to be the appropriate level of care, since arriving in Guatemala, the patient has not received medical treatment (Zoellner, 2010). Medical repatriation is becoming a more widely used practice in hospitals facing these circumstances. In fact, it has been documented that a Phoenix hospital repatriates nearly one hundred patients per year (Zoellner, 2010), and at least one company exists that specializes in finding placements in and transporting patients back to Latin America (Dwyer, 2009).

The aforementioned case shares implications in case management, ethics, and cultural competence. Nursing case managers must adhere to the *Standards of Professional Performance,* which states that the nurse is guided by the *Code of Ethics for Nurses* (Powell & Tahan, 2010). Some of the ethical principles listed in the Code of Ethics for Nurses are being violated in this case study, such as non-maleficence, advocacy in terms of facilitating access to needed services (Powell & Tahan, 2010), and deliverance of care in a manner that is sensitive to cultural diversity (Powell & Tahan, 2010). Cultural competence in this case study involves the case manager’s need for awareness of the health care disparities that exist with the undocumented immigrant community, examining one’s own feelings with regard to undocumented immigration, and the knowledge of interventions that can potentially help this underprivileged population.

**Improving Case Management Practice by Exercising Cultural Competence**

Cultural competence with regards to health care can be defined as the ability of the healthcare provider to render effective services to diverse cultural and ethnic patient populations (Carr, 2006). In the case of the undocumented immigrant population, cultural competence is absolutely necessary. Becoming culturally competent allows the case manager to assist in the delivery of quality services to underserved, racial/ethnic groups by valuing cultural differences and incorporating cultural attitudes, beliefs, and practices into the diagnostic and treatment process (Carr, 2006).

First and foremost, case managers need to explore their own feelings towards undocumented aliens. Doing so allows the case manager to take an honest and introspective look at personal biases that may exist towards this specific population of people. Meeting the cultural, ethical and health care needs of the undocumented immigrant population can only take place once personal biases towards this population are assessed and accepted by the case manager.

Cultural competence with this population also involves relating to, and being sensitive to the motives one has to enter the US unlawfully; such examples include the desire to earn more money, provide better support for their families, construct better lives, and to escape poverty, unemployment, war, and environmental degradation (Dwyer, 2009). Recognition of these factors help the case manager gain some perspective with regards to some of the biases he or she may have toward undocumented immigrants, which may in turn, influence the case management process. Using the example from the case study, a culturally competent case manager would likely be so empathetic towards the hurdles and disparities that the undocumented immigrant population encountered in their lives, that all other possible options and interventions to reduce health care costs and provide quality care would have been investigated thoroughly before considering medical repatriation. Transferring the patient to a long-term facility under its charity care program is an option that can be explored; although charity care resources are becoming depleted due to overuse from uninsured persons (both citizens and the undocumented), transferring the patient to several long term care facilities allow the client’s cost of care to be split amongst several facilities, as opposed to just one. Home care services may also be available through the home care company’s charity care provision, if possible (Carr, 2006). Inpatient hospitals that have a continuum of services within it, such as sub-acute care, home health services, and skilled nursing facilities, make options even greater, and therefore should also be explored (Carr, 2006). Medical repatriation may be the last option available; if so, it should be agreed upon, and involve participation of the patient / family.

The more that case managers understand and relate to one’s culture, the more they are able to improve case management practice by incorporating those factors into the patient’s plan of care. With regard to undocumented immigrants and the disparities they experience in health care, Dwyer (2009) said it best by stating that although, “there is no denying that undocumented workers have violated a law by either entering or staying in a country; but it does not follow that they have no ethical right or claim to health care services” (Dwyer, 2009). Exercising cultural competence and cultural sensitivity toward the undocumented population sets the stage for the case manager to best represent the interests of the patient and family with the highest level of advocacy with regard to ethical matters and dilemmas, while simultaneously providing quality and cost effective care appropriate to the patient’s needs.

References

Carr, D. D. (2006). Implications for Case Management: Ensuring Access and Delivery of Quality

Health Care to Undocumented Immigrant Populations. *Lippincott’s Case Management, 11*(4),

195-204.

Dwyer, J. (2009). When The Discharge Plan is Deportation: Hospitals, Immigrants, and Social

Responsibility. *Bioethics, 23*(3), 2-4.

Passel, J., & Cohn, D. (2011). Unauthorized Immigrant Population: National and State Trends,

2010. Retrieved on April 23rd, 2012, from

http://pewhispanic.org/reports/report.php?ReportID=133

Powell, S. K., & Tahan, H. A. (2010). *Case Management: A Practical Guide for Education and*

*Practice* (3rd Edition)*.* Philadelphia, PA: Wolters Kluwer Health / Lippincott Williams &

Wilkins.

Zoellner, E. R. (2010). Medical Repatriation: Examining the Legal and Ethical Implications of

an Emerging Practice. *Journal of Law & Policy, 32*(5), 515-538.

Zuckerman, S., Waldmann, T. A., & Lawton, E. (2011). Undocumented Immigrants Left Out Of

Health Reform, Likely To Continue To Grow As Share Of The Uninsured. *Health Affairs,*

*30*(10), 1997-2004.