Capella University

Ethical Case Studies

Main Content

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Consider the ethical dilemma the health care professional is faced with in the selected case study. Pay particular attention to details that will help you analyze the situation using the three components of the Ethical Decision Making Model (moral awareness, moral judgment, and ethical behavior).

Note: The case study may not supply all of the information you may need for the assignment. In such cases, you should consider a variety of possibilities and infer potential conclusions. However, please be sure to identify any speculations that you make.

Incident 2: Emergency Department Repeat Admissions — A Question of Resource Use

Matt Losinski finished reading an article that provided grim details of a study of

the overuse of emergency services in hospitals in central Texas. He smiled that sardonic half smile that meant there was a strong possibility that County General Hospital (CGH) might have the same problem. As chief executive office (CEO), Losinski always saw the problems of other hospitals as potential problems at CGH, a 300–bed, acute care hospital in a mixed urban and suburban service area in the south central United States. CGH was established as a county–owned hospital; however, 10 years ago the county wanted to get out of the hospital business and the assets were donated to a not–for–profit hospital system. The new owner has continued a strong public service orientation, even though CGH no longer receives the tax subsidy it did when it was county owned; it must look to itself for fiscal health.

The study data showed that nine residents of a central Texas community had been seen in emergency departments (EDs) a total of 2,678 times over 6 years. One resident had been seen in an ED 100 times each year for the past 4 years. Given that an ED visit can cost $1,000 or more, the nine residents had consumed $2.7 million in resources. These high users of ED services were middle age, spoke English, and were split between male and female. To Losinski, the problem seemed like a manifestation of Wilfredo Pareto's classic 80/20 rule.

Losinski forwarded the article on a priority basis to Mary Scott, his chief financial officer (CFO), and asked her to see him after she read it. Scott stopped by Losinski's office late the next day and began the conversation by asking him why he thought the article was a priority. Scott reminded Losinski that Medicaid paid 75% of costs for eligible ED users and that the cross subsidy from privately insured and self–pay ED admissions covered most of the unpaid additional costs. Losinski had a good working relationship with Scott, but he was a bit annoyed by her rather indifferent response.

Losinksi wanted details on use of the ED at CGH. He asked the administrative resident, Aniysha Patel, to gather data to identify use rates for persons repeatedly admitted to the ED. The findings that Patel gave to Losinski two weeks later were not as extreme as those reported from central Texas; however, they did show that a few persons were repeatedly admitted to the ED and accounted for hundreds of visits in the past year. The clinical details were not immediately available, but a superficial review of the admitting diagnoses

suggested that most admissions involved persons with minor, nonspecific medical problems—persons commonly known as the “worried well.” Although Scott was correct that Medicaid covered the majority of costs, the fact remained that over $200,000 each year was not reimbursed to CGH. Were that money available, it could go directly to the bottom line and could be used for enhancements to health initiatives for the community. In addition, repeated admissions to the ED contributed to crowding, treatment delays, and general dissatisfaction for other patients.

Losinski presented the data to his executive committee, which includes all vice presidents, the director of development, and the elected president of the medical staff. The responses ran the gamut from “So what?” to “Wow, this is worse than I imagined.” Losinski was bemused by the disparity of views. He had thought there would have been an almost immediate consensus that this was a problem needing a solution. The financial margins for CGH were already very thin, and the future for higher reimbursement was not bright. A concern echoed by several at the meeting was the requirement of the federal Emergency Medical Treatment and Active Labor Act (EMTALA) that all persons who present at an ED that receives federal reimbursement for services must be treated and stabilized.

Losinski asked his senior management team for recommendations to address the problem of ED overuse.

Incident 9: The Missing Needle Protector

E. L. Straight is director of clinical services at Hopewell Hospital. As in many hospitals, a few physicians provide care that is acceptable, but not of very high quality; they tend to make more mistakes than the others and have a higher incidence of patients going “sour.” Since Straight took the position 2 years ago, new programs have been developed and things seem to be getting better in terms of quality.

Dr. Cutrite has practiced at Hopewell for longer than anyone can remember. Although once a brilliant general surgeon, he has slipped physically and mentally over the years, and Straight is contemplating taking steps to recommend a reduction in his privileges. However, the process is not complete, and Cutrite continues to perform a full range of procedures.

The operating room supervisor appeared at Straight's office one Monday afternoon. “We've got a problem,” she said, somewhat nonchalantly, but with a hint of disgust. “ I'm almost sure we left a plastic needle protector from a disposable syringe in a patient's belly, a Mrs. Jameson. You know, the protectors with the red–pink color. They'd be almost impossible to see if they were in a wound.”

“Where did it come from?” asked Straight.

“I'm not absolutely sure,” answered the supervisor. “All I know is that the syringe was among items in a used surgical pack when we did the count.” She went on to describe the safeguards of counts and records. The discrepancy was noted when records were reconciled at the end of the week. A surgical pack was shown as having a syringe, that was not supposed to be there. When the scrub nurse working with Cutrite was questioned, she remembered that he had used a syringe, but, when it was included in the count at the conclusion of surgery, she didn't think about the protective sheath, which must have been on it.

“Let's get Mrs. Jameson back into surgery.” said Straight. “We'll tell her it's necessary to check her incision and deep sutures. She'll never know we're really looking for the needle cover.”

“Too late,” responded the supervisor, “she went home day before yesterday.”

Oh, oh, thought Straight. Now what to do? “Have you talked to Dr. Cutrite?”

The supervisor nodded affirmatively. “He won't consider telling Mrs. Jameson there might be a problem and calling her back to the hospital,” she said. “And he warned us not to do anything either,” she added. “Dr. Cutrite claims it cannot possibly hurt her. Except for a little discomfort, she'll never know it's there.”

Straight called the chief of surgery and asked s hypothetical question about the

consequences of leaving a small plastic cap in a patient's belly. The chief knew something was amiss but didn't pursue it. He simply replied there would likely be occasional discomfort, but probably no life–threatening consequences from leaving it in. “Although,” he added, “one never knows.”

Straight liked working at Hopewell Hospital and didn't relish crossing swords with Cutrite, who, although declining clinically, was politically very powerful. Straight had refrained from fingernail biting for years, but that old habit was suddenly overwhelming.

Incident 10: To Vaccinate, or Not?

Jenna and Chris Smith are the proud parents of Ana, a 5–day–old baby girl born without complications at Community Hospital. Since delivery, the parents have bonded well with Ana and express their desire to raise her as naturally as possible. For the Smiths, this means breastfeeding exclusively for the first six months, making their own baby food using pureed organic foods, and not allowing Ana to be vaccinated.

The Smiths are college educated and explain they have researched vaccines and decided the potential harms caused by them far outweigh any benefits. They point to the rise in autism rates as proof of the unforeseen risk of vaccines. Their new pediatrician, Dr. Angela Kerr, listens intently to the Smiths' description of their research, including online mommy–blogs that detail how vaccines may have caused autism in many children. The Smiths conclude by resolutely stating they've decided not to vaccinate Ana, despite the recommendations of the medical community.

Dr. Kerr begins by stating that while vaccines have certainly sparked controversy in recent years, she strongly recommends that Ana become fully vaccinated. Dr. Kerr explains that vaccines have saved the lives of millions of children worldwide and have been largely responsible for decreases in child

mortality over the past century. For example, the decreased incidence of infection with the potentially fatal Haemophilus influenzae type b, has resulted from routine immunization against that bacterium. Similarly, epidemics such as the recent outbreak of measles are usually associated with individuals who have not been vaccinated against that pathogen.

Dr. Kerr goes on to endorse the general safety of vaccines by informing Ana's parents that safety profiles of vaccines are updated regularly through data sources such as the federal government's Vaccine Adverse Event Reporting System (VAERS). The VAERS, a nationwide vaccine safety surveillance program sponsored by the Food and Drug Administration and the Centers for Disease Control and Prevention, is accessible to the public at https://vaers.hhs.gov/index. This system allows transparency for vaccine safety by encouraging the public and healthcare providers to report adverse reactions to vaccines and enables the federal government to monitor their safety. No vaccine has been proven casual for autism spectrum disorder (ASD), or any developmental disorder. On the contrary, many studies have shown that vaccines containing thimerosal, an ingredient once thought to cause autism, do not increase the risk of ASD.

Finally, Dr. Kerr reminds the Smiths that some children in the general population have weakened immune systems because of genetic diseases or cancer treatment, for example. It may not be medically feasible to vaccinate such children. Other children are too young to receive certain immunizations. Instead, these children are protected because almost all other children (and adults) have been vaccinated and this decreases their exposure to vaccine–preventable illnesses (VPIs). This epidemiological concept is known as “herd immunity.” As more parents refuse immunization for their healthy children, however, the rate of VPIs will increase. This puts vulnerable children at significant risk of morbidity and mortality. Routine childhood immunization contributes significantly to the health of the general public, both by providing a direct benefit to those who are vaccinated and by protecting others via herd immunity. Dr. Kerr concludes by stating that after considering the risks versus the benefits of immunization, most states require vaccinations before children can attend school. Parents may decide not to vaccinate under specific circumstances, however, which vary by state.

Jenna and Chris Smith confirm their understanding of what Dr. Kerr has explained, but restate that they do not want Ana vaccinated at this time. Dr. Kerr is perplexed as to what to do.

References

In Darr, K., In Farnsworth, T. J., & In Myrtle, R. C. (2017). *Cases in health services management.*

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