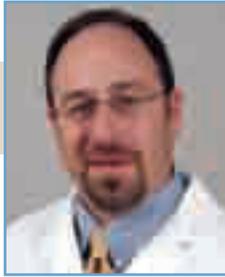


Medical Ethics



By Jonathan Evans, MD, MPH, CMD

Culture Change and Ethics in Health Care

The Case

An 87-year-old, female nursing facility resident was awakened in the morning by a nursing assistant who informed her it was time to get dressed. With mild dementia, a history of stroke, left-side weakness, osteoarthritis, and urinary incontinence, the resident required assistance with all activities of daily living.

The nursing assistant had selected clothing from the resident's closet and had begun to dress her when the resident stated, "I don't want to wear those pants. They are too hot and too loose on me."

The nursing assistant replied, "Sweetie, I'm in a hurry. I don't have time to get you different clothes." She continued to dress the resident, who became upset. "You're mean!" she told the nursing assistant. The staff member subsequently reported to the nurse on duty that "7A is agitated."

The nurse called the physician to report a change in the resident's condition, saying, "The patient is agitated and resisting care." The nurse requested an order for a urine culture and "something to calm [the resident] down." The physician agreed. A medication was ordered to be administered immediately and "as needed."

Discussion

This case symbolizes, among other things, an impersonal, institutional, medical culture of conformity and control, a culture that is centered around the facility and the routines of its staff, rather than on the people receiving care. In this medical and institutional culture, patients may be thought of or even referred to by their diseases, rather than by their names. Personal choices are limited.

While the case described is set in a nursing facility, a similar scenario could just as easily have taken place in a hospital.

The phrase "culture change" could mean just about anything, but in the context of long-term care it means something fairly specific: a national movement to transform facilities from institutions to home environments and to transform attitudes within health care settings. The goal is to change health care and related services from provider centered and provider directed to person centered and, ultimately, person directed. In the language of medical ethics, culture change aims to promote greater patient autonomy, self-determination, and personal decision making.

An important goal of culture change is to "demedicalize" life. Current medical culture views life from the perspective of the provider. The environment (both

human and physical) in which medical care is delivered automatically becomes "medicalized" as a result.

Physically, most older nursing facilities were made to look like hospitals of their day, with hospital beds, shared rooms and bathrooms, and long corridors marked by central nursing stations off limits to residents. Medical environments provide little space for personal belongings, and little opportunity for privacy.

In hospitals and still in many nursing facilities alike, staff are identified by their uniforms. Their ranks, titles, and role are distinguishable by their clothing. Names are consigned to small badges.

Medical culture has for thousands of years been paternalistic. Patient autonomy is a very recent construct. The federal Patient Self-Determination Act did not come into existence until 1990. Prior to that, a person's decision that differed from his or her doctor's was considered "against medical advice." Even now, that pejorative phrase is commonplace, along with all of its punitive consequences.

In medical settings, basic aspects of living and personal choice require a physician's order: the choice of food one eats, whether and for how long one may be out of bed, consumption of an alcoholic beverage, leaving the premises, even taking a vitamin. Similarly, bedtime, wake time, mealtime, activities, and when a medication is taken are decisions by and large made by others.

The Myth of Autonomy

Autonomy – the right to make up your own mind – is often no more than an abstraction in health care. That's because the right to do something and the ability to do it are two different things.

Autonomy is meaningless without power. Exercising your right to self-determination requires power. For people who are disabled or unable to communicate, getting that power requires the cooperation and assistance of others.

Self-determination also requires having real choices. Henry Ford's famous quip when Model Ts came only in black demonstrates that freedom of choice means nothing when there is nothing to choose from.

What the culture change movement in long-term care is really about is power. It involves shifting power from those who provide care and services to those who receive them. This requires providers not only to give up power voluntarily but also to empower others to intervene as advocates and champions of patients and their families.

Long-term care settings have been the

initial focus of the culture-change movement primarily because, historically, nursing facilities have been permanent homes for millions of people. Viewed from this perspective, what has historically been wrong with long-term care is that it isn't homelike because it is medical.

The public is more accepting of hospitals being medical environments. People expect it, and they don't have to live there. At least as important as the phys-

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ical environment, however, are the medical attitudes in medical environments. Changing the physical space helps to change attitudes and expectations but doesn't do the whole job of changing a culture.

Several large-scale studies have shown that the strongest predictor of antipsychotic drug prescribing in nursing facilities is the culture of the facility, not the medical diagnoses or disease severity of the patients who reside there. This is one of the strongest proofs that the culture in nursing facilities really does need to change. Where it has, quality measures and clinical outcomes have improved.

Long-term care has been in the forefront of change – ahead of hospitals – on many issues, including elimination of physical restraints, scrutiny of polypharmacy and unnecessary drugs, pressure ulcer prevention, and more.

Language is a fundamental aspect of culture. Much of the language of medicine is negative. Physician visits center around a "complaint." The absence of a symptom is often noted as the patient "denying" chest pain, heartburn, or another symptom. A desire to forego testing or treatment is typically referred to as a "refusal" of care or "noncompliance." Likewise, patronizing terms such as "sweetie" or "dear," while they may be well meant, can be as impersonal as referring to someone as the old demented lady, a diabetic, or simply as a room number. Changing the culture, therefore, requires changing the language.

Culture Change Risks and Barriers

Few of us working in health care believe that we, as individuals, are part of the

problem. On the contrary, we consider ourselves to be caring professionals with patient-centered attitudes. That's what we've always been. We tend to regard change as something that others must do. Perhaps the biggest barrier to culture change, therefore, is this form of inertia.

But the opposite – rapid change in our industry – may also be a barrier. At the same time that the culture change movement is trying to transform nursing facilities into homes, many of those facilities are shifting to deliver more short-term, postacute care that is increasingly medical. This latter change is driven by money: Society wants to decrease overall health care expenditures by shifting as much care as possible from hospitals to less expensive sites.

The move toward medically complex and more-acute care is embraced by most nursing facility operators as critical to their survival, yet it may undermine long-term care culture change. An increased presence of medical equipment, more responsibility for facility staff to deliver medical rather than personal care, and residents who do not intend to call the nursing facility "home" other than for a short stay all threaten to make nursing facilities even less homelike.

Moreover, ongoing efforts to eliminate the 3-day hospital-stay requirement for Medicare Part A to cover a nursing facility stay have the potential to further transform nursing facilities from places to live to places to leave.

Nevertheless, success in changing the culture within nursing facilities can show residents, families, staff, and communities a positive option to medicalized care. Ultimately, LTC culture change can influence environments and attitudes in hospitals and all other health care settings by raising expectations, including those of regulators, payers, and staff. Ideally, changing the culture of medicine may help to create a more positive, healthier, and more respectful society for everyone, one that empowers individuals to achieve and maintain their fullest potential.

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