
CASE REPORT

An ethical dilemma in a hospice setting

ROBIN L. McMAHON, LCSW, BCD

The Catholic University of America, National Catholic School of Social Service, Washington, D.C.

(RECEIVED June 21, 2002; ACCEPTED September 26, 2002)

ABSTRACT

The codes of ethics of the National Hospice and Palliative Care Organization and the National Association of Social Workers support ethical standards of client self-determination and confidentiality. Lack of societal consensus on the parameters of a terminally ill person's right to die continues to confound at times the health care field, including hospice programs. This article explores an actual case where a hospice social worker faced an ethical dilemma related to the sanctity of life versus patient autonomy. While a more seasoned social worker might have chosen a different alternative to the dilemma, this case illustrates the importance of creating an interdisciplinary rather than multidisciplinary hospice team and the need for ongoing dialogue on how to support patient choice.

KEYWORDS: Social work ethics, Hospice, Suicide, Patient choice

INTRODUCTION

In the 20th century, life expectancy for the average American increased from 47 years in 1900 to 83 by the end of the millennium. Vast improvements in medical treatment, vaccines to eliminate diseases like polio and small pox, technology to transplant organs, and machinery to pinpoint malfunction in the human body have enabled an extended life span for many. Yet, the enhanced ability to prolong life brings with it the potential for a protracted dying process. In addition, sophisticated medical technology has contributed to skyrocketing costs for health care and controversy about allocation of resources.

Medical cost containment issues and decisions surrounding when it is time to die have created a practice environment of conflicting responsibilities and choices for health care clinicians. Biomedical ethics committees and extensive medical ethics literature have emerged as signs of increased recognition of the need for ongoing dialogue about ethical

dilemmas. Accomplishments in the area of bioethics include laws and statutes supporting advance directives and informed consent. These measures have, in principle, empowered competent individuals to make choices about their own bodies, while relieving physicians and families of the burden of "playing God" or guessing what an incompetent patient would have wanted.

Despite such policies that reflect legal and ethical mandates regarding client autonomy, some patients continue to acquiesce to the medical "experts" without being fully apprised of their choices. Social workers in health care may be caught between the holistic values of the social work profession and the opposing principles and perspectives of the predominant medical model of patient care, which often emphasizes treating the body rather than the whole person. Dilemmas arise where individual self-determination is juxtaposed with an attitude of paternalism still found in health care (Greipp, 1996). Social workers, as patient advocates first and foremost, and as members of an interdisciplinary team second, must weigh their allegiances carefully when intervening with clients. This article explores an actual case where a social worker faced an ethical dilemma which pitted the value of the sanctity of

Corresponding author: Robin L. McMahon, The Catholic University of America, National Catholic School of Social Service, 5909 North 22nd Street, Arlington, VA 22205. E-mail: rlmcmahon@erols.com

life against a client's right to autonomy in deciding when to terminate his life. The ethical quandary encompassed issues related to a patient's right to self-determination and confidentiality, which conflicted with agency policies and procedures, the social worker's responsibility to collaborate with colleagues, and professional duty to intervene. The social worker's limited experience in working within the interdisciplinary team further heightened the dilemma. No doubt, many who read this article will disagree with the outcome. In reality, the author intentionally used this questionable decision as a stimulus to continued discussion of supporting patient choice at end of life and the richness of perspectives embodied in an interdisciplinary team. Some facts have been altered to protect the privacy of the client and family and the professional integrity of health care workers involved.

The four-step ethical decision-making model developed by Joseph (1985) will be used to frame the process adopted by the social worker in this scenario. The first step of the model is to identify the practice situation and the central ethical dilemma. Second is a review of literature supporting each side of the conflict. The third step of the model is to identify values and relevant ethical principles, in this case ethical standards from both the medical and social work professions, as well as client values.

These values are then placed in hierarchical order of significance to the ethical conflict. An important part of the model at this point is to explicate any of the social worker's personal biases that may influence the decision-making process. In the last stage—selecting a course of action to resolve the ethical dilemma—the model requires discernment of options and projection of the consequences of each choice. Finally, the ethical decision is stated, along with justification of the resolution (Joseph, 1985).

PRACTICE SITUATION

The social worker involved in the selected practice situation was a hospice employee rendering professional services to a dying patient and the patient's family and friends. Hospice services are available to persons with a terminal diagnosis of approximately six months or less. An interdisciplinary team of nurses, social workers, chaplains, home health aides, volunteers, physicians, and complementary therapies provide care in partnership with patients and their caregivers. Hospice emphasizes a holistic approach, recognizing that the spiritual and emotional needs of clients are just as important as physical comfort. Hospice philosophy promotes death with dignity, patient choice, and quality of life, according to each patient's unique definition (Greipp,

1996). The hospice program involved in the ethical dilemma was a member of the National Hospice and Palliative Care Organization (NHCPO, formerly NHO), which developed a code of ethics to guide hospice practice in 1996. Neither the hospice program nor NHCPO supports assisted suicide, suicide, or euthanasia. In fact, the hospice movement promotes hospice care as a viable alternative to assisted suicide (National Hospice Organization, 1990). The client, Allen, was a 62-year-old married male with metastatic prostate cancer. Shortly after his initial diagnosis, he refused all life-extending options: surgery, chemotherapy, and radiation, choosing quality over quantity of life. He believed that the side effects of any life-prolonging procedure would diminish his enjoyment of living. Allen was also adamant that he did not want to become a burden to his family. Two years after the initial diagnosis, Allen was admitted to hospice care.

Allen died 7 months after his admission to hospice. As part of the scope of emotional and spiritual support, Allen's social worker contacted the patient and/or family weekly by phone and visited according to their wishes. On average, the social worker visited three times a month and the nurse visited twice a week. Allen had refused a hospice chaplain or volunteer, as he had a large support group of friends through a 12-step program, in addition to his spouse and adult daughter. For the first 6 months Allen was able to engage in activities outside his house, but gradually became dependent on others to drive him, and eventually found it too much of an effort to leave his home. Despite being housebound, the patient remained involved with others through daily phone calls from his support network.

As is sometimes the case in hospice, patients are more comfortable sharing thoughts and concerns about dying with experienced staff and volunteers. In keeping with his need to stay in control, Allen openly discussed his feelings with his social worker and nurse while protecting family and friends from his fears of dying and his unwillingness to be dependent on others for his total care.

ETHICAL DILEMMA

Several months prior to his death, Allen revealed to the social worker that his physician had provided him with the means to end his life when he deemed his quality of life inadequate. The patient underscored that his method was such that the cause of death would appear to be a heart attack and that no one would suspect otherwise. He acknowledged that he wanted to be in control of his living and admitted concerns about being a burden to his wife, who was 20 years younger. In defining quality of life, Allen

named factors such as independence, preservation of dignity, and maintenance of mental faculties. While the social worker believed it possible that Allen would in the future follow through with his plan, she chose to maintain confidentiality regarding the patient's disclosure and the physician's complicity in providing a method. The social worker did not report to the nurse, other members of the interdisciplinary team, or the social work supervisor of the suicide potential, as was required by agency policy, which would have allowed input from other staff. Nor did the social worker notify the patient's family members, who were each considered clients as well. At the end of a lengthy social work visit where Allen reflected on his sense of peace and completeness, he remarked to the social worker that he was bidding her a final goodbye. The social worker was not surprised when she arrived at work on Monday to learn that the patient had died of an apparent heart attack.

There was little question for the social worker that Allen's death was the result of a successful suicide attempt. Both Allen, the doctor, and the social worker made choices that permitted the patient to end his life according to his own timing rather than waiting for the natural process of dying to occur. The central dilemma for the social worker when the patient first stated his intention to commit suicide and later implied that it would occur was between the social worker's duty to protect the sanctity of life by actions to prevent a suicide attempt and her obligation to preserve a client's right to self-determination by nonintervention, thereby respecting the patient's autonomy to control the time and mode of his death. The clinician was responsible for maintaining confidentiality in the therapeutic relationship and thus supporting patient autonomy. This duty conflicted with imperatives to adhere to agency policy and procedures for responding to a potential suicide and with hospice interdisciplinary team practice to communicate identified problems to other staff members. Another complication was the professional value to protect a client from "imminent danger" or the physical harm implied by the client's plan to kill himself. One additional confounding factor was the social worker's therapeutic relationship with the patient's family, which dictated attention to the well being of family members. Thoughtful exploration of the ethical dilemma also requires examination of suicidality as a manifestation of mental illness and as a moral concern.

HISTORICAL AND CONTEMPORARY VIEWS ON SUICIDE

Euthanasia and suicide have been the subject of theological and philosophical debates for thousands

of years in the Western world. Euphemisms for the word suicide, a term first documented in the 17th century, range from self-deliverance and self-chosen death to self-annihilation and self-murder (Shneidman, 1973). The connotations of these expressions illustrate the emotional and intellectual reactions of self-induced death. The ancient Greeks and Romans held diverse points of view on the morality of self-inflicted death, which stimulated ethical discourse throughout subsequent centuries.

The rise of Christianity solidified a negative position on suicide as sinful and criminal. Although the Bible does not specifically prohibit suicide, St. Augustine condemned self-murder as a mortal sin according to the Sixth Commandment, "Thou shalt not kill" (Exodus: 20:13). (St. Thomas Aquinas proclaimed that suicide was a sin, a human act against natural law. He asserted that killing oneself is an act that harms the entire community. More importantly, suicide is an act in opposition to God, who provided life as a gift, and should determine when a person dies.)

A modern voice denouncing suicide was that of Immanuel Kant. Despite his support for personal autonomy, Kant stated that suicide, even in situations of suffering and loss of control, is an irrational action reflective of lack of self-respect. The philosopher concluded that suicide is never morally justified under any circumstances: "suicide is not . . . abominable because God has forbidden it; God has forbidden it because it is abominable in that it degrades man's inner worth below that of animal creation" (Kant, 1997, p. 124). It must be noted that not all religions universally vilify suicide. Some Eastern cultural rituals support self-inflicted death as an honorable practice involving altruistic sacrifice. "Suttee," the Hindu widow's fatal leap onto the funeral pyre of her spouse, was an accepted custom for many centuries (Shneidman, 1973). Altruistic self-chosen deaths are not unique to eastern religions: Many saints of Catholicism were martyrs who favored death over dishonor.

Allen, the client in the practice situation, died in the 1990s in the context of a widening societal debate about an individual's choices in dying and a more compassionate attitude about self-intentioned death for terminal patients. Although suicide is no longer considered a crime in the United States, facilitating the death of another continues to be prohibited by law. However, defendants are often acquitted by judges and juries for their acts of mercy. Physician-assisted suicide, euthanasia, and death with dignity continue as rallying cries of two decades of controversy regarding a person's "right to die." In 1980, Derek Humphry and others formed the Hemlock Society in the United States to edu-

cate the public on methods to end life. In 1991 Humphry published his how-to manual for committing suicide, *Final Exit*. Pathologist Jack Kevorkian entered the headlines with his suicide machine and faced criminal charges for assisting persons in terminating their lives. Also in 1991, Dr. Timothy Quill's *New England Journal of Medicine* article and subsequent book, spurred further debate on the notion of "death with dignity." Quill outlined narrowly defined criteria for a physician to participate in aiding a terminal patient's death (1993). In her "Apologia for Suicide," Barrington (1987) explains societal disdain for suicide as mirroring cultural discomfort with the idea of death. Weir (1986) defines the right to die as the individual's prerogative as an autonomous moral agent to terminate one's life when quality of life is severely diminished. Brandt's approach to self-initiated death allows that suicide can be a rational and morally accepted act; however, consideration of the well-being versus harm to others must also be included in any decision to end life (Brandt, 1986).

THEORETICAL PERSPECTIVES ON SUICIDE

Just as cultural, philosophical, and religious perspectives on self-administered death vary, in the clinical realm, sociologists and mental health professionals may view suicide as a result of mental illness, a function of inadequate social integration, or a rational choice under discrete circumstances. The medical model diagnoses suicidality as a mental disorder requiring treatment. Karl Menninger characterized suicide as self-destruction emanating from the three-pronged nature of human hostility—the wish to kill and be killed and the desire to die (Purtillo & Cassell, 1981). Freud visualized suicide as the supremacy of the death force, *thanatos*, over its twin life instinct, *eros* (Kastenbaum, 1995). A key concept of psychodynamic theory—ambivalence—is reflected in the paradoxical nature of suicide, where the individual often moves toward self-destruction while hoping for discovery and rescue (Shneidman, 1973).

Many health care professionals who acknowledge that suicide can be a rational decision are careful to qualify this concept with discrete conditions. Of prime importance is the mental competence of the person contemplating life cessation. Cognitive functioning and psychological balance are crucial elements of the capacity to make decisions regarding life and death. Werth (1996) promotes the possibility of suicide as a rational decision and presents situations where mental health professionals may discern that intervention to prevent a log-

ically considered suicide is inappropriate. Likewise, Quill (1993) argues that suicide to alleviate intolerable suffering may be a reasonable alternative to continued distress. In a contrasting perspective on anguish in the dying process, Vanderpool (1978) and Barry (1994) regard suffering as an opportunity for the development of meaning and virtues such as patience, humility, and courage.

Noted thanatologist and suicidologist Edwin Shneidman (1973) subscribes to the phenomenon of ambivalence in a person's attitude toward death. Although he does not consider psychological life as "rational" or "logical," he characterizes the death initiator as someone who believes death is imminent and commits suicide in order to avoid the negative conditions of the dying process. In an early psychological study analyzing the content of suicide notes, Shneidman and Farberow (1959) described a concept similar to self-initiated death called "surcease suicide," a "logical" type practiced by individuals "typically older, widowed, and in physical pain." Shneidman suggests yet another condition for rational suicide, namely that it is a carefully considered and durable choice devoid of hesitation over time.

In evaluating the practice dilemma, it is important to examine the fears surrounding the dying process that may precipitate an individual's action to intentionally terminate life. Simpson (1979) enumerates fears of the dying process including pain, discomfort, and loss of control of physical abilities and/or cognitive functioning, loss of independence, inability to communicate, and finally, loss of dignity. Schulz (1978) describes the desire to avoid being an emotional or financial burden to loved ones as a motivation to end life through suicide. Attention to fears of dying is an important part of the therapeutic relationship between a clinician and a terminally ill patient. Quality of life can be enhanced when an individual is able to verbalize fears and adapt to losses or changes as they occur.

IDENTIFICATION OF SOCIAL WORK VALUES: DIGNITY AND WORTH OF THE PERSON

A guiding principle in the hospice field is promoting quality of life for each patient based on his or her unique definition. Empowerment of the individual is an important tool for facilitating quality of life. The National Association of Social Workers (NASW) *Code of Ethics* enumerates ethical principles related to dignity and worth of the person which parallel fundamental hospice values (National Association of Social Workers, 1996).

One aspect of the ethical dilemma confronting this social worker was patient autonomy to commit

an act contrary to hospice philosophy and practice. Biestek (1957, p. 103) describes the principle of self-determination as “the practical recognition of the right and need of clients to freedom in making their own choices and decision . . . ,” yet cautions that this right is “limited by the client’s capacity for positive and constructive decision making, by the framework of civil and moral law, and by the function of the agency.” Support for the client’s right to self-determination could potentially condone actions viewed as posing a risk to the individual and violating the rules of the agency. The standard for self-determination stated in the Code of Ethics is

Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals. Social workers may limit clients’ right to self-determination when in social workers’ professional judgement, clients’ actions or potential actions pose a serious, foreseeable, imminent risk to themselves or others. (National Association of Social Workers, 1996, 1.02, p. 7)

Patient autonomy to make life-affecting decisions in health care must be girded with accurate information about alternatives, comprehension of the facts of the situation, and explanation of the consequences of choices. It is the professional’s role to ensure that the patients receive sufficient data to make an informed choice, without influencing or dictating the final decision (Latimer, 1991). One threat to a patient’s right to self-determination in health care decision making is an attitude of paternalism, which may be conveyed by a demeanor which implies that the clinician, not the client, knows “best.” The Hospice Code of Ethics also includes autonomy as one of the fundamental ethical principles of health care as “the ability to determine a course of action for oneself” (National Hospice Organization, 1996).

Confidentiality, based on an individual’s right to privacy and self-determination, is one of the core principles of the casework relationship enumerated by Biestek (1957), in the social work classic, *The Casework Relationship*. Respect for the private confidences of a client is a crucial element in promoting the dignity and worth of the person. According to Reynolds (1976), individuals will refrain from revealing intimate information necessary for the therapeutic process without some implied or explicit assurance that the disclosure will remain private. One of the precepts of the National Hospice and Palliative Care Organization’s Code of Ethics (1996) is “to respect and protect the confidentiality of information concerning hospice clients and fam-

ilies.” Dellinger (1997) delineates the end-of-life intimate communications that hospice workers may facilitate or witness, including “revelations, confessions, efforts at reconciliation and final declarations” (p. 45). Despite its endorsement of the social worker’s ethical responsibility to “protect the confidentiality of all information obtained in the course of the professional relationship,” the NASW Code of Ethics (1996) also permits exceptions for “compelling professional reasons” when “the disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or others” (1.07c). Likewise, Reamer (1990) notes that the common belief held in the social work profession is that confidential information shared by a client can be revealed solely under special circumstances. Biestek (1957) underscores that confidentiality is not an absolute right, especially if preservation of confidentiality conflicts with the rights of other individuals, the rights of the social worker, or the rights of the agency through which the social worker is providing services. Moreover, legal precedents define the relative nature of confidentiality. The classic court case, *Tarasoff v. Regents of University of California*, illustrates a situation where the court determined a clinician legally bound to report a client’s disclosure regarding intended harm toward another (Dellinger, 1997).

ETHICAL PRINCIPLES: BENEFACTENCE, NONMALEFACTENCE, AND JUSTICE

In evaluating a patient situation involving terminal illness and the possibility of further abbreviating a finite existence through suicide, the principles of beneficence (to prevent harm and do good) and nonmaleficence (to not inflict harm) are strongly intertwined. The imperatives embodied in these principles raise conflicting responsibilities depending on whether suicide is viewed as a competent choice to alleviate suffering. Beneficence and nonmaleficence must also be considered in relation to the patient, the patient’s family, the social worker, the hospice interdisciplinary team, and the hospice agency. In addition, the impact of the social worker’s decision and the patient’s choice on the hospice movement and society itself are relevant to consider in terms of how they promote good, prevent harm, and refrain from inflicting harm. Any course of action based on beneficence or nonmaleficence for one of the actors involved in the ethical quandary might potentially create harm to others.

The principle of justice is highly valued in the social work profession and in hospice care. Concepts of fairness and entitlement of individual rights

versus potential harm to others are considerations that must be weighed in resolving the ethical dilemma. The Hospice Code of Ethics defines justice as “Fairness: dealing suitably with individuals; giving individuals what they are due or owed; distributing benefits and burdens (e.g., of healthcare) fairly” (NHO, 1996, p. 80). Similarly, the social work Code of Ethics states that in order to challenge social injustice, “Social workers strive to ensure . . . meaningful participation in decision making for all people” (National Association of Social Workers, 1996, p. 5).

DEVELOPING A HIERARCHY OF VALUES

To resolve the ethical dilemma, the social worker must order salient ethical values, principles, and duties. A blending of the parallel intents of the NASW and NHPCO codes of ethics provides a basis for hierarchical assignment of ethical considerations.

1. **Self-determination.** Nearly three decades ago, the Hospice movement was founded on the principle of patient choice in dying. Self-determination remains the keystone of current hospice practice (Duff, 1979). Likewise, autonomy is related to the dignity and worth of the person, one of the important values of the social work profession. An NHPCO publication delineates conditions for autonomy: “the capacity for understanding, the capacity for deliberation, and the capacity to make autonomous choices” (NHO, 1993).
2. **Sanctity of life.** Second in order of importance in the hierarchy is the value of life and individual and professional responsibility to protect and enhance life.
3. **Nonmaleficence.** The principle of not inflicting harm is a crucial guideline in all helping professions.
4. **Beneficence.** Promoting good and preventing harm within the client system is a prized goal in social work and hospice care.
5. **Professional integrity and service.** These two values are interconnected in the practice situation and require the social worker to intervene with the client system utilizing a high level of professional knowledge and skill and honesty and trustworthiness in relationships with patients.
6. **Confidentiality.** Maintaining confidentiality is fundamental to any therapeutic relationship. The social work profession does not support absolute confidentiality. Maintaining

confidentiality must be weighed according to benefits of individual privacy versus protection of others from harm.

7. **Interdisciplinary collaboration.** Teamwork is the foundation of hospice practice. Maximizing the skills of each member of the interdisciplinary team is achieved through collaboration of information, perspective, and knowledge (Pellegrino & Thomasma, 1981).
8. **Justice.** Ensuring that each client served by the hospice team is offered equal opportunities for resources, information, and services is a value consistent with the social work profession and hospice philosophy.

PERSONAL AND PROFESSIONAL BIASES

Attention to the personal and professional biases of the clinician is essential to systematic ethical decision making. Issues such as the social worker’s personal views on quality of life and sanctity of life influence objectivity. Although hospice programs and, theoretically, their agents or staff support patient choice to refuse or discontinue artificial life-prolonging procedures, it does not necessarily follow that staff also subscribe to proactive discontinuation of life itself, preempting the natural course of death. The social worker’s religion and personal and professional experiences with suicide must be noted.

CONSIDERATION OF ALTERNATIVES

In the final stage of the ethical decision-making process, the options for intervention and the likely consequences of each alternative must be weighed. The relative merits of competing goods and the effects of possible harm are assessed according to the prioritized ethical principles and values. In the clinical scenario, the social worker’s options included: (1) supporting Allen’s choice to end his life when he discerned that his quality of life was insufficient; (2) intervening to prevent a future suicide; (3) maintaining confidentiality about the patient’s future wishes, but exploring with the patient his motivations and the possible ramifications of his decision; (4) sharing with the interdisciplinary team the patient’s stated wish to end his life, thus including the team in the decision-making process.

Supporting the patient’s decision to control the timing of his death would be consistent with ranking self-determination as the preeminent value in the hierarchy. The second value in the hierarchy, life, would conflict with respecting

self-determination, unless the sanctity of life is viewed as embodied in the concept of quality of life. As previously stated, many ethicists consider ending a life of suffering a moral act which is not contrary to valuing the precious gift of existence. The social worker's support for the possibility of patient suicide at some point in the dying process would not abdicate professional responsibility for intervention to enhance the patient's physical, emotional, and spiritual well-being in conjunction with services provided by other members of the hospice team. Collaboration to promote the patient's quality of life would imply a series of therapeutic actions recognizing the sanctity of life, and promoting hierarchical values of nonmaleficence, beneficence, professional integrity and service, and even justice for the patient. Confidentiality would also be maintained to protect client autonomy and to prevent any premature intervention by the hospice team to remove the patient's option to suicide if efforts had not achieved sufficient quality of life.

The option to support patient wishes would pose potential harm to the other parties involved including the patient's family, the social worker, and the hospice organization. The social worker's responsibility to prevent and not inflict harm for the other clients, the family, would be undermined by supporting a patient choice which is beneficent and nonmaleficent for Allen, but not for his family. The well-being of the family would depend on their acceptance or rejection of the patient's choice and their perspective on suicide as a rational and justified decision or an immoral action. As noted earlier, maintaining confidentiality in instances of imminent danger, as the family might interpret the patient's desire to end his life, often results in legal action. By keeping silent about the patient's intention to end his life, the social worker would be exposing herself and her agency to legal liability, a significant harm. The social worker's professional integrity might be impugned by family members who felt betrayed and uninformed hospice team members who had not been informed. The social worker's employer, the hospice organization, would most likely question the social worker's professional judgment in not adhering to agency policy. Further implications for the social worker in supporting the patient's right to self-determination would arise if the social worker rejected rational suicide as a moral action. The social worker's personal and professional well-being would be jeopardized by participation in an action inconsistent with her belief system. Any publicity which might arise from legal action by the family would most certainly damage the social worker's reputation and falsely convey an image of hospice as a facili-

tator of assisted suicide. From the standpoint of the value of justice, families of former hospice clients might feel that loved ones with a similar wish to end their lives sooner than the biological process allowed had not been offered a choice by the hospice organization or the social worker involved. Current and potential hospice patients or families might either fear or advocate for the possibility of hospice-sanctioned self-induced death, thus creating long-term confusion about hospice philosophy. Taking into account the many potential risks of this first alternative, from a utilitarian perspective, upholding the patient's right to self-determination would not allow the greatest good for the greatest number.

In the second option, an alternative to permitting self-inflicted death is to initiate a suicide prevention plan to promote the value of life and support death through the natural body process. Although self-determination is ranked the highest value in the ethical decision-making hierarchy of principles and values, if suicide under any conditions is deemed morally wrong or an irrational act regardless of the patient's competence, responsibilities to prevent harm and do good would require intervention to prevent the patient from acting on suicidal intent. In this scenario, divulging private information would not be considered inflicting evil or harm on the patient because the greater good would be preservation of the sanctity of life. Additionally, suicidal intentions would constitute "compelling professional reasons" for breaking confidentiality (National Association of Social Workers, 1996, 1.07c).

Nevertheless, in reality, the trusting relationship between clinician and client would erode, possibly irreparably. Avoidance of patient suffering could not be guaranteed; however, the hospice team would offer support to the patient and family in coping with the physical, emotional, and spiritual dimensions of the patient's illness and the issue of restricted patient autonomy. Finally, though the patient would not be afforded "meaningful participation in decision making," one aspect of social justice—the general welfare of past, present, and future hospice clients—would be protected by consistency in hospice philosophy and practice with respect to suicide (National Association of Social Workers, 1996). In this instance, from a utilitarian perspective, the greatest good for the greatest number would occur.

The fourth option available was for the social worker to trust in the collective wisdom of the interdisciplinary team in order to resolve the dilemma. This action would protect the social worker from sole responsibility for such a weighty decision but would also open up the possibility of direct confrontation of the patient's wishes and revelation of the social worker's breach of confidentiality.

ETHICAL DECISION AND JUSTIFICATION

Despite the social worker's own discomfort with the idea of suicide, she chose to respect the self-determination of her patient by acting on a third option, that is, to maintain confidentiality while also directly addressing the implications of future suicide. The social worker's intention was not to dissuade the patient from his choices, rather to encourage him to fully examine the alternatives and the possible consequences for family. If Allen still chose to end his life, the social worker would explore with him whether his means of ending his life was indeed guaranteed to succeed in painlessly terminating life and in being undetectable as suicide. This clinician recognized that prostate cancer can create an uncomfortable dying process or a more certain physical decline where the patient is dependent on others for total care. For Allen, the choice to avoid likely dependence and possible discomfort by ending his life appeared to be a rational decision. The social worker also recognized a duty to mitigate any harm to the other parties involved, including the family, the hospice team, and the hospice organization. She also sought to protect her reputation, with the belief that the professional skill that she had acquired through her experiences in hospice should not be undermined for current and future patients. Lastly, the social worker identified the detriment to the hospice movement in setting a publicly acclaimed precedent of sanctioning patient suicide. The social worker's professional knowledge that most hospice patients, even those who fear a painful death and mention self-inflicted death, ultimately die comfortably, solidified her resolve to prevent the patient's action from becoming public knowledge.

The social worker adopted a teleological rationale for her determination to support Allen's right to choose. For each decision, which proceeded from resolution of the central dilemma, the social worker made choices and selected interventions by weighing the consequences. To support the value of sanctity of life, through her weekly counseling sessions and in collaboration with the hospice nurse, the social worker used her professional knowledge and skill to encourage and empower the patient to maximize his quality of life. Allen's ambivalence and fears about the dying process were addressed to ensure that any decision would be informed and rational. As the patient's pain increased, the hospice team alleviated Allen's discomfort. Rather than ending his life when he first needed assistance and care, the patient allowed others to assist him. The social worker helped him to recognize the gift of

giving that he had bestowed on loved ones that wanted to care for him. Allen waited until he was close to losing his ability to implement his suicide method to end his life. He firmly believed that he should protect his family from any added turmoil which raising the issue of suicide might create and thus chose to not include them in his deliberations. The social worker ascertained with the patient that his means of self-administered death would be "fool-proof" and, in fact, discovered that the patient's physician prescribed the needed medication prior to the patient's admission to hospice.

The consequences of actions taken to resolve the ethical dilemma were that a patient died with minimal suffering and in a manner consistent with his own values of quality of life. Other parties involved were protected from harm by their lack of awareness of the patient's decision. For the social worker, as a human being who valued the precious life of Allen and as a professional dedicated to enhancing the final stage of life, the ethical conflict was not easily resolved. The clinician made her decision based on the unique circumstances of Allen's life and illness, upholding the patient's self-determination to make a decision even when it conflicted with agency policy and the social worker's beliefs. That Allen's circumstances were unique has been borne out in the social worker's subsequent experience.

In years since Allen's death, the social worker continued to encounter patients who raise self-administered death as a possible course of action. In each of these cases she intervened to address issues of depression, anxiety, ambivalence about death, and fears of the dying process. She also informed patients and families at the time of her first visit that important information revealed to one member of the interdisciplinary team was shared with other members. In most instances, further intervention to prevent suicide has not been needed. For the exceptions, the social worker has collaborated with hospice team members to institute a plan for suicide prevention, while exploring and validating the patient distress surrounding the conditions the patient finds intolerable. Even in these situations, through vigilant management of physical symptoms, increased sedation, or counseling related to emotional or spiritual distress, most patients appear to experience minimal suffering.

REFERENCES

- Barrington, M.R. (1987). Apologia for suicide. In *Taking Sides: Clashing Views on Controversial Bioethical Is-*

- sues, Levine, C. (ed.), pp. 132–141. Guilford, CT: Dushkin Publishing Group.
- Barry, R.L. (1994). *Breaking the Thread of Life: On Rational Suicide*. New Brunswick, NJ: Transaction Publishers.
- Battin, M.P. (1994). *The Least Worst Death: Essays in Bioethics on the End of Life*. New York: Oxford University Press.
- Biestek, F.P. (1957). *The Casework Relationship*. Chicago: Loyola University Press.
- Brandt, R.B. (1986). The morality and rationality of suicide. In *Ethical Issues in Death and Dying*, Weir, R.F. (ed.). New York: Columbia University Press.
- Dellinger, A.M. (1997). Legal requirements for confidentiality in Hospice care. *The Hospice Journal*, 12, 43–48.
- Duff, R. (1979). Guidelines for deciding care of critically ill or dying patients. *Pediatrics*, 64, 17–23.
- Greipp, M.E. (1996). The hospice choice: Ethical decision making. *The American Journal of Hospice and Palliative Care*, Sept./Oct., 28–34.
- Joseph, M.V. (1985). Ethical decision-making in clinical practice: A model for ethical problem-solving. In *Advances in Clinical Social Work*, Germain, C.B. (ed.), pp. 207–217. Silver Spring, MD: National Association of Social Workers.
- Kant, I. (1997). *Lectures on Ethics*. Translated by Heath, P., Heath, P., & Schneewind, J.B. (ed.). New York: Cambridge University Press.
- Kastenbaum, R. (1995). *Death, Society, and Human Experience*. Needham, MA: Allyn & Bacon.
- Latimer, E.J. (1991). Ethical decision-making in the care of the dying and its applications to clinical practice. *Journal of Pain and Symptom Management*, 6, 329–336.
- National Association of Social Workers. (1996). *Code of Ethics*. Silver Spring, MD: National Association of Social Workers.
- National Hospice Organization (1990). *Resolution Approved by Delegates at Annual Meeting*. Detroit, Michigan.
- National Hospice Organization (1993). *Discontinuation of Hospice Care: Ethical Issues*. Arlington, VA: National Hospice Organization.
- National Hospice Organization. (1996). Hospice Code of Ethics. *Hospice Journal*, 11, 75–81.
- Pellegrino, E.D. & Thomasma, D.C. (1981). *A Philosophical Basis of Medical Practice*. New York: Oxford University Press.
- Purtillo, R.B. & Cassell, C.K. (1981). *Ethical Dilemmas in the Health Professions*. Philadelphia: W.B. Saunders.
- Quill, T.E. (1993). *Death and dignity*. New York: W.W. Norton & Co.
- Reamer, F. (1990). *Ethical Dilemmas in Social Service*, 2nd ed. New York: Columbia University Press.
- Reynolds, M.M. (1976). Threats to confidentiality. *Social Work*, 12, 108–113.
- Schulz, R. (1978). *The Psychology of Death, Dying and Bereavement*. New York: Addison Wesley Publishing Co.
- Shneidman, E.S. (1973). Suicide. In *The Encyclopedia Britannica*, pp. 383–385. Chicago, IL.
- Shneidman, E.S. & Farberow, N.L. (1959). Suicide and death. In *The Meaning of Death*, Feifel, H. (ed.), pp. 284–301. New York: McGraw Hill.
- Simpson, M. (1979). *The Facts of Death*. Englewood Cliffs, NJ: Prentice-Hall, Inc.
- Vanderpool, H. (1978). The ethics of terminal care. *Journal of the American Medical Association*, 239, 850–852.
- Varga, A.C. (1978). *On being human*. New York: Paulist Press.
- Weir, R.F. (1986). *Ethical Issues in Death and Dying*. New York: Columbia University Press.
- Werth, J. (1996). *Rational suicide? Implications for mental health professionals*. Washington, DC: Taylor & Francis.