

Health care disparities in care of elders

An interview with Gloria Ramsey, JD, RN



A registered nurse and attorney, Dr. Gloria Ramsey is known for her work in bioethics; in particular, her research has focused on questions concerning end-of-life care, decisional capacity in the elderly, and legal and ethical issues for individuals and families with HIV disease and AIDS. Currently, she is the

director of Community Outreach and Information Dissemination at the Center for Health Disparities Research and Education at the Uniformed Services University of the Health Sciences in Silver Spring, Maryland. Dr. Ramsey's clinical interests include ethical issues in clinical practice, ethics education and consultation, and the unique ethical and legal issues that arise in nursing practice.

Can you tell us about your current work in health disparities, and how it relates to our discussion on nurse advocacy in long-term care?

The question of *health disparities* (differences between two or more population groups in health outcomes and in the prevalence, incidence, or burden of disease, disability, injury, or death) and *health care disparities* (differences between two or more population groups in health care access, coverage, and quality of care, including differences in preventive, diagnostic, and treatment services) is an important one for health professionals across all health care settings; however, it is particularly important for nurses who are nursing home resident advocates. Older adults, by virtue of their age and disability, may experience different care and, therefore, are among America's most vulnerable. The American Nurses Association Code of Ethics, Provision One, (See page 1, lead article.) sets forth a moral mandate that is increasingly important when disparities in health care is well documented and the U.S. Department of Health and Human Services (HHS) has made eliminating health disparities by 2010 a national goal.

What are some of the most important domains to consider when we think of the long-term care nurse's role as advocate?

The Institute of Medicine in 2002 reported in *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* that minorities are less likely than whites to receive needed services, and differences in treating heart disease and cancer con-

tribute to higher death rates for minorities. Socially and economically challenged persons are often at a disadvantage to access health information, including end-of-life education, and they often die in pain and suffer needlessly. Thus, it is important for nurses to be knowledgeable about end-of-life care and the disparities that occur in this area, particularly with regard to the assessment and management of pain.

In your view, what kinds of disparities exist in end-of-life care?

System issues, resident issues, and provider issues all affect access to quality end-of-life care. The nursing home is responsible for establishing a culture and organizational process that supports timely, comprehensive, compassionate end-of-life care. Lack of interpretation and translation services, time pressures on health providers, particularly nursing and social work, add to the disparities that exist at the end of life.

Older people may not report their pain, either because they assume that pain is normal in old age, or due to cultural, historical, linguistic, or cognitive barriers. Some older adults view pain

“. . . about 20 percent of the U.S. population has advance directives.”

as a metaphor for death or serious illness, and are reluctant to acknowledge it. Finally, certain cultural groups believe there is nobility in suffering, or place value on enduring through a struggle.

Provider issues that contribute to disparities in end-of-life care include lack of knowledge about pain and its management, failing to stay current with new treatment modalities, and belief in myths about pain.

What are some of the legal implications or trends in regard to pain management?

There was a case not long ago in California in which a physician was held liable for undertreatment of a patient's pain in a long-term care facility. The resident had serious pressure sores and the physician was found to be negligent in pain management. An increasing number of states are now mandating that physicians receive education in pain management, and it is also a nurse's ethical responsibility to do the same.

DEA (Drug Enforcement Agency) scrutiny of physician prescribing patterns could be a deterrent to proper pain management. However, as this case suggests, physicians can be held

continued on page 6

Monthly Interview

continued from page 4

liable for NOT prescribing pain medication. The American Pain Foundation and others played a role in educating the DEA in preventing physicians from being sanctioned for providing adequate pain control to their patients.

Would you comment on the importance of advance directives and the nurse's role in this?

Survey data suggest that about 20 percent of the U.S. population has advance directives. For racial and ethnically diverse populations, the rate of advance directive completion is lower. Reasons cited for barriers to completion include distrust of the health care system, health care disparities, and cultural perspectives on death and dying. Notwithstanding, it is important

"Learn the language of palliative and end-of-life care . . ."

that the nursing home is engaged in ongoing communication among staff, residents, and families about goals of care at the end of life. It is equally important that all staff learn how to communicate with culturally diverse persons, and understand how culture affects decision-making.

Do you have any further comments on the long-term care nurse's role as resident advocate, particularly at end of life?

Health care professionals have a responsibility to acquire and maintain competencies in end-of-life care. Learn the language of palliative and end-of-life care, and how to communicate with residents, family members, or other surrogates and staff from diverse cultures and ethnic backgrounds. Programs such as Caring Connections' "It's About How You LIVE" campaign has state-specific advance directives and can answer questions about care at the end of life. Visit them at www.caring-info.org or contact 1-800-658-8898. ■

The LTC nurse as advocate

continued from page 3

portant part of the nurse's role as advocate is ensuring that anyone to whom tasks are delegated is competent to provide that care.

Long-term care nurses also play an important role in identifying practices or conditions that could pose a safety risk to residents. This includes medication administration policies, staffing inadequacies (in terms of competency or adequate numbers), and environmental hazards, among others. Individual nurses are morally obligated to prevent harm to residents by intervening on multiple levels if necessary. For example, a nurse is ethically bound to take immediate steps to ensure resident safety, and to report a

coworker's incompetent, unethical, or illegal activities (e.g., arriving for work intoxicated), via appropriate internal (and external, if necessary) channels.

A wider sphere of influence

The ANA Code of Ethics for Nurses addresses the responsibility of nurses, individually and through professional nursing organizations, to address societal issues that have an impact on patient (resident) care. For example, nurses can be instrumental in promoting public policies that ensure high-quality long-term care, by working with legislators and by raising the community's awareness of the relevant issues. ■

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