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Decision-Making and Nurse Case Management
A Philosophical Perspective

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Decision-making related to resource allocation in home care case management practice is addressed from the unique perspective of nursing. The case management process stipulates the adherence to both client-centered and system-centered goals. Issues that emerge from this process include the ethical dilemma of deciding the equitable and fair distribution of resources related to the provision of appropriate levels of service; economic factors as they relate to limited financial resources; and the variance among case managers in their decision-making. Moderate realism, as compared to critical and feminist theory, provides a philosophical perspective that allows a practical interpretation of these issues. **Key words:** *case management*, *case manager*, *critical theory*, *decision-making*, *feminism*, *home care*, *moderate realism*, *resource allocation*

HOME CARE is changing rapidly within an environment of health care reform, an aging population, and economic constraints. Programs are expanding to meet the increased demands created from several sources. These include decreasing number of beds in acute care, increasing waitlists for long-term care, increasing number of children and young adults with complex physical[1] and mental health care needs living in the community, and an increasing aging population particularly in the "old-old" age bracket when frailty and health issues are more prominent.[2] With increasing demand for home care, the issue of resource allocation, particularly financial resources, is gaining more attention from managers, policymakers, politicians, academics, and practitioners. Resource allocation mechanisms and the associated decision-making processes are recognized for their complexity and are frequently not explicit enough to adequately guide decision-makers whether it be at the managerial level or at the clinical frontline.

In this article the issue of decision-making related to resource allocation in home care case management practice from the unique perspective of nursing will be addressed. The particular challenges of decision-making within nurse case management practice in home care will be highlighted. It will be argued that moderate realism,[3] because of its practicality and grounding in reality, is the most appropriate perspective to inform our understanding of these issues.

CASE MANAGEMENT AND HOME CARE

Smith and Smith[4] outline case management as a process intended to facilitate access to health care services. It includes assessment, planning, coordination, delivery, and the monitoring of services provided to individuals and families. The goals of case management are cost containment while maintaining quality of care and managing complex internal and external relationships related to service delivery.[5–7]

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Historically, the notion of case management within a milieu of managed care emerged in the early 1990s as a major force in organizing health care service.[8] Managed care, a term often used in concert with case management, has become a "generic label without a clear, universally accepted definition and is most commonly operationalized through the process referred to as 'case management.'"[8(p81)] Kersbergen[9] defined managed care as a business framework for organizing the delivery of health care services while controlling service and resource utilization through incentives to control costs and decision-making based on business parameters. It was described as a means to gain better control over costs and management in the process of solving health care problems and providing better health care services.[8]

As this managed care framework became more prominent, more and more care was transferred from hospitals to community-based services. Home care programs expanded and offered increasingly diverse, complex, and expanded services and it used case management as a means of allocating resources for the delivery of these services. Although various professionals including social workers, physiotherapists, and occupational therapists can carry out the various roles of case management, in home care, case managers most often are registered nurses with baccalaureate degrees.[4] According to these authors nurses are often seen as particularly suited for case management roles because of their broad range of assessment and coordination skills related to health. In this article, therefore, the relationship between case management and resource allocation decision-making will be considered from the unique perspective of nursing only. Subsequently, the term *case manager* and *nurse* will be synonymous and used interchangeably.

CASE MANAGEMENT AND NURSING

Nursing was quick to embrace case management as it was seen as an opportunity for nurses to influence the health care system, to keep the nursing perspective visible, and to have increased authority to improve quality of care.[8] Although case management was even recognized as a form of advanced nursing practice,[6] tensions within case management practice soon emerged. The case management process, similar to the nursing process, involved assessment of client needs, planning of care, allocation of resources for the services required to meet those needs, and ongoing coordination, monitoring, and evaluation of the care provided. According to Cesta and Falter[10] and Padgett[6] when these components are taken together, the primary goals of case management, that is, providing quality client care while containing costs within the health care system, are achieved.[10] It is this embedded duality of both client-centered and system-centered goals, however, that frames the primary cause of the ethical dilemmas faced by case managers.[6]

To expand, client-centered goals[6] of case management are to promote well-being, optimize individual health status and functioning, and help the client achieve mutually agreed upon outcomes of care. The coordination of services ensures clients receive the right services, at the right time, and by the right provider. Quintessential to successful case coordination is the quality of relationships between case managers and their clients/families and the clarity of communicating the plan of care to other health care providers involved with the provision of care.[4,11,12] The achievement of the client-centered case management goals is possible only if integrity is maintained within these relationships and communication patterns. Additionally, when required, case managers also play an empowerment and advocacy role on behalf of their clients.[6]

System-centered goals, on the other hand, focus on cost-efficiencies and cost-containment, policy directives, eligibility criteria, and utilization patterns. Cost-efficiencies are achieved when the best possible care in the most efficient manner is provided. Cost-containment is controlling

the care that is delivered within a limited and set amount of dollars. Policy directives and eligibility criteria are intended to guide the case manager's decision-making about resource allocation or service delivery. Utilization patterns assist case managers in their overall planning and budgeting process.

The client-centered and the system-centered goals appear in direct conflict with each other, yet case managers are accountable for both.[6–9] Conflicts arise in cases where clients may believe they need additional services, while case managers balance those requests against program standards, norms, and individual eligibility criteria. Case managers must judge individual client needs against the available resources within a specific plan of care and the entire home care program. The dissonance arises when case managers fully appreciate the extent of client need while recognizing the limited resources available to them to meet those needs.

Additionally, a diversity of complex skills and knowledge is required to be successful as a case manager. Kersbergen[9] identified these skills to include abilities to advocate for clients, collaborate with clients, families and other health care workers, assess and plan for client service needs efficiently and accurately, delegate, negotiate, analyze costs and benefits of care, understand the provision of services across the continuum of care, predict client outcomes, collect and evaluate outcome data, and understand financial data and business planning. It is the recognition of the ethical components in the performance of these skills that increases the discord within case management practice and affects how decisions are made and how resources are allocated.

DECISION-MAKING AND RESOURCE ALLOCATION WITHIN CASE MANAGEMENT

Complex decisions are made within every step of the case management process; ie, assessment, planning, coordination of services, and evaluation and discharge. At each step case managers consider the resources available to them while making decisions that are most appropriate to the particular situation and that directly affect the type and quality of services to be delivered. Resource allocation encompasses more than just the distribution of dollars. It includes the means by which the services are to be delivered, the types of services that are to be provided, and who will provide them.

The breadth and depth of this home care perspective are evident in the type of decisions a case manager must make. For example, decisions are made around the following types of questions: will services be directly provided by home care or will they be contracted to another agency; what type and number of personnel are available to provide services – professional and/or support services; which services can be delegated to unregulated workers; how much time is to be allotted for particular tasks; how long is a client eligible for services; and what type of supplies and equipment are necessary for the services to be delivered? Within home care, it is the case manager who makes these decisions. It is the case manager who authorizes the services and it is within the case management process that the allocation of the associated resources is determined.

When making these kinds of decisions case managers are juggling many competing factors, all with varying levels of importance depending on who and how these factors are interpreted. The case manager must evaluate the rival components and make judgments that are suitable to meet client's needs while remaining synchronous with the cost-containment goals of the health care system. This results in extensive variation in the decisions that are made.

It is recognized that case managers do have certain tools such as service eligibility criteria,[13] care maps, clinical pathways, and peer consultation to assist them in this decision-making process.[8] Eligibility criteria are explicit criteria that dictate whether a client is eligible for a home care program.

Clinical guidelines and protocols, care maps, and clinical pathways are terms that are often used interchangeably, most often referring to guidelines and standardized care protocols for a given condition or functional ability. They are tools that assist the case manager in predicting level of resources for a given client state. Although these tools are invaluable supports and act as important guidelines, in the end, case managers are essentially on their own when it comes to the actual decisions that must be made relating the services that will be provided and the types of workers who will provide those services. Additionally, these supportive tools have been developed using the best available evidence-based practices and the latest research. The intention for their use in case manager decision-making is to decrease variance among case managers so that the best possible outcome is possible.[8,14] However, case managers, in their efforts to be responsive to client need may modify these standardized tools to fit unique client situations. These individualized modifications, although well intentioned, then result in further variations in decision-making.

Decision-making is an intricate and convoluted process. Thompson[15] describes decision-making as nonlinear in nature and is the process by which nursing knowledge is operationalized into practice. Decision-making is often described as an either/or process.[3,16] In nursing and in case management, however, decision-making is uniquely situated and embedded within the context of practice making it difficult if not impossible for nurses and case managers to use an either/or prescriptive approach. Rather, Thompson contends that decision-making should be regarded on a continuum, not as an either/or process.[15] Thompson claims that both the humanistic-intuitive approach and the systematic-rational approach are insufficient on their own as a means to understanding "decision-making and by implication the information used as the basis for nursing decisions."[15] It is, however, important to note that both contribute to the decision-making process. The way the pendulum swings on the continuum is dependent on many influencing factors including context, client assessment data, and budgetary restraints. The continuum paradigm is similar to the approach suggested by Kikuchi and Simmons[3] as they discuss the moderate realist perspective in clinical judgment. This will be explored further in subsequent sections of the article.

Although the individuality of clients creates the opportunity for creativity within case manager decision-making process,[17] decision-making within home care also presents challenges as case managers seek to achieve consistency, appropriateness, and equity among their clients. These challenges are evident when what seems appropriate for one client might not be suitable for another although both have similar health concerns. One client might require considerably more services than another in order to facilitate a similar outcome, perhaps, due to factors such as variable levels of informal family support or the cognitive and/or physical abilities of the client or their spouse. Hence, home care case managers must rely on reasonable judgment[18] and common sense when making decisions about the services they will provide to their clients, in addition to having excellent assessment skills. This discretionary practice is required to meet individual client needs; but it also leads to further inconsistencies amongst case managers resulting in fragmentation and perhaps, inappropriate delivery of services.

DECISION-MAKING ISSUES IN CASE MANAGEMENT

In discussing the juxtaposition of decision-making with regard to resource allocation in case management, a number of issues become evident. The most common ones are focused in the areas of ethics and economics as they relate to the practical aspects of the authorization and delivery of services. Ethical dilemmas revolve around the equitable and fair distribution of resources particularly as they relate to a case manager's interpretation of

system-centered goals versus client-centered goals. Economic issues arise when budgetary restrictions within the health care system constrain case managers in making decisions that may not be the most appropriate to meet client need. Practical issues are related to the variance in nursing judgment and the fact that the decision-making tools available to home care case managers are guidelines only and are not intended to be prescriptive in nature.

The ethics in deciding the equitable and fair distribution of resources related to the provision of appropriate levels of service and health care providers are influenced by several factors. The expertise and personal belief systems of case managers, the social and family networks of clients, the health status of clients, the manner in which the case is presented to the case manager, and geography may influence resource allocation decision-making by case managers.[14,19] For example, if case managers perceive that family members are *unable* to provide informal support, they may offer different levels of service than they would have offered if their perception was the family members *unwillingness* to provide that support. Or, case managers may tend to be more sympathetic to difficulties within family caregiver situations perhaps because of personal experience and may make quite different decisions than case managers who have not had such personal experience. Within a framework of fairness and equity the overriding question remains, are the services allocated in such a way that the needs of all clients are appropriately met? Are case managers making decisions reflecting the right amount of services and the appropriate level of care provider to meet the needs of their clients? The dilemma lies in how these decisions are made because they directly influence the resources consumed within home care programs.

Economic issues emerge at both the client and the system levels. At the client level, issues arise when home care policies dictate capitation per client, particularly in situations where clients with high needs exceed the established limit. Case managers must then decide whether they are willing and resourceful enough to advocate on behalf of such clients for the additional required resources. For case managers such efforts can be time consuming and complex with no guarantee of success. Within the health care system, where home care budgets are finite and perhaps underresourced[14,20] case managers are acutely aware of the direct relationship between limitations within budgets and the client services they authorize. They are required to make decisions that keep services within budget all the while recognizing that these may not be adequate to meet client needs. How successfully case managers navigate through these thorny issues is grounded in their expertise and mastery of the skills as outlined by Kersbergen[9] and profoundly influences the resource allocation process.

The practical issues emanating from these complexities also influence how resources are allocated. The variance among case managers in the decisions they make about allocation of services[21] is particularly problematic. This variation can be linked to the education and expertise of case managers.[9] It can also be related to factors such as the individual case manager's interpretation of a client situation or the rural, urban, remote locations of home care programs. For example, what one case manager, in one setting might interpret as an appropriate level of service, might be interpreted as entirely inappropriate and inadequate by another case manager in another environment. Because decision-making about service allocation occurs at the individual case manager level, the risk for inconsistencies in resource allocation is high. It is the individual case manager who has to interpret the information gathered from the various decision-making tools being used in consideration of the unique client data gathered at the time of the assessment. For example, although eligibility criteria policies and guidelines might be in place in a particular home care program, how they are understood and used by case managers within that program might be quite different. The outcome for clients is that the services they receive are

dependent on which case manager has assessed them; one case manager might authorize services while another might not. Such practical issues create enormous education and policy challenges for home care organizations, all with significant implications for resource allocation. There are great variances both in home care budgets and in the type and quality of services being provided to clients.

These case management decision-making issues have a significant impact on clients being served and on the available resources of the home care program in general. By highlighting the extent to which these issues influence both the quality of client services and the availability of resources within home care programs, the need to explore the philosophical underpinnings that might shed some light on these issues becomes evident. To interpret these issues from a philosophical perspective and to find possible reasons for their existence may provide home care case managers support, direction, and guidance as they continue in their efforts to appropriately meet the needs of clients within the constraints of limited resources.

PHILOSOPHICAL CONSIDERATIONS IN HOME CARE RESOURCE ALLOCATION

Various philosophical perspectives could inform us about the issues outlined in previous sections. In this article the discussion is limited to 3 such perspectives to include critical theory, feminism, and moderate realism. Critical theory and feminism are more prevalent in the nursing literature[6,22,23] than is moderate realism, and have significantly influenced decision-making in terms of resource allocation and the nature and scope of home care in general. Moderate realism,[3] on the other hand, is an emerging philosophical stance that is presented here as a more suitable conception for nursing decision-making. It gives consideration to the sensible modification of rules and principles that out of necessity must be done by case managers from time to time so that a "fit" with specific practical circumstances can be accommodated. Hence, it allows for the intentional and planned inclusion of both client and system perspectives in the decision-making process within the home care context.

Critical theory

Critical theory, emerging out of the Frankfurt School in Germany in the 1930s, is gaining significant influence within the nursing discipline.[24] Its main features center around domination, power, transformation, and dialogue.[25] From the perspective of historical determinism, critical theory articulates a process of defining a multiple reality in the "present" so that liberation from past entrenchments can occur. The domination of history and past events need not continue into present circumstances. Through dialogue, reflection, and informed understanding among people, new emancipatory and liberating actions can occur. Within these interactive processes, the new knowledge and insights gained are always contextually and socially situated.[26] Within critical theory, there is no one universal truth! Rather, in the process of continually searching for a deeper understanding of unique circumstances and the meaning of individual experience through emancipatory discourse, new knowledge is generated.[26,27]

At first glance, it would appear that critical theory lends itself well to interpreting the interactions that occur within case management practices in home care. The discourse that occurs between and among clients, case managers, assorted health care workers, supervisors, families, and policy makers is complex with potential for domination by a powerful few. Those making decisions regarding the allocation of resources can be seen as having particular power. The ideal within this dynamic interactive state is shared autonomy and responsibility among the various players. However, difficulties emerge when determining, among the array involved players, where the power or the oppression is situated. From the client perspective, the case

manager may seem all-powerful in the allocation or withholding the resources for adequate service delivery. From a macro system perspective the case manager situation too may be seen as oppressed, being dominated by those in the system who establish the policies regulating the amount and method of resource distribution. There is a silence, however, within critical theory about the nature and quality of human caring, commitment, compassion, and justice,[28] the foundational components of the interplay among the various players within case management practice. Critical theory helps us to establish the nature of power within case management practice but it does not address the dynamic interplay amongst its various players.

Another criticism of critical theory, particularly in relation to case management practice, lies in its core valuing of the discursive and multiple nature of truth and its lack of attention to "the ethics of accountability."[28(p384)] In programs, such as home care, where service volumes can be large and resources finite, certain policies must exist to ensure equitable and appropriate distribution of available resources. Critical theory might influence the decision-maker to elucidate those factors that either facilitate or constrain decisions made about the allocation of resources. It might even promote emancipatory action where oppressed voices are heard. It does not, however, seem to help case managers integrate the multiple truths of the individual experiences within their practice with the rules and regulations and the enactment of the ethics of accountability that guide their decision-making practices.

Feminist theory

Feminist theory has also been gaining influence within the nursing discipline[24] as evidenced in the nursing literature. Feminist theory features gender inequality as central while seeking to understand the diversity of human experience.[2] In its more radical versions, feminism asserts an emancipatory purpose, akin to critical theory, seeking to reveal injustice in the human experience, particularly the feminine experience.[29] From a gentler perspective, it aspires to speak to and be grounded in everyday life characterized by relatedness, contextual orientation, and subjective human experience.[26,29] Although we recognize that a feminist empiricist stance exists, the notion we are discussing is grounded historically in the work of Gilligan.[30] This notion recognizes that men and women engage in moral reasoning differently; men use more formal or universalistic procedures whereas women make more situational choices based on responsibility and commitment to others.[2,24] Given the diversity of feminist theory, there is unity in the general perspective that feminism seeks to improve the lot of women and that it is imbedded in idealism and optimism.[29] As well, there is unity in the idea that caregiving, whether it be formal or informal, is seen as the domain of woman's work and is usually not recognized as highly valued productive work.[2]

Because nursing is predominately a female profession, there is a particular resonance between feminist theory and nursing practice. Within home care particularly, a common experience is women nurse case managers interacting with women informal family caregivers in the home. Within the context of the home environment, it is women in dialogue with other women, each interpreting from their unique perspective the need for services, how those needs will be met, and each trying to decipher the others ability to provide those services. Ultimately, the decisions that must occur are made within these relational and contextual boundaries; that is, within the parameters of the system in which the service occurs.

Feminist theory can be helpful in interpreting certain aspects of the decision-making issues related to the allotment of services within home care. From its relational and contextual perspective, feminist theory helps explain why case managers struggle with the ethical dilemmas of having to make decisions about inadequate service authorization because of economic constraints. To be

required to make decisions that could be interpreted as mitigating against the commitment and responsibility to the "other," could generate significant moral dissonance and alienation within case managers. It could also be argued from a feminist perspective, that the "poor cousin" status of home care within the larger health care system is linked to the notion that the work of home care is in the women's sphere of responsibility and therefore, not requiring equivalent resources to the other male dominated sectors within the system.

Because of its foundational and historical perspectives of gender differences in moral reasoning, however, feminist theory does not adequately help to interpret the wide variations among case managers in their decisions about resource allocation among clients. It could be related to the fact that more men are entering case management practice and that more men find themselves in roles of informal family caregiving.[12] This seems unlikely, however, given the gradual gender shift occurring in nursing and therefore, case management and in informal caregiving.[31] The notion that decisions about resource allocation are gender based with gender differences in the processes and outcomes of these decisions seem too narrow an interpretation. Given the contextual complexity of these decisions, some of the more strident articulations of feminism do not seem adequate in explaining the practicalities of resource allocation in case management.

Moderate realism

Relative to critical and feminist theory moderate realism is a comparatively new philosophical influence within the nursing discipline. Moderate realism as articulated by Kikuchi and Simmons[3] addresses the influence of moderate realism on practical nursing judgment. They state that moderate realism is "a common-sense philosophy which attains its principles by reflecting on common-sense knowledge and reasoning therefrom in light of available evidence."[3(p44)] Commonsense knowledge is described by these authors as judgments arising from our common sense that includes such knowledge formulated out of past experience, mere opinion, probable truths, and absolute truths. They identify 3 key canons of moderate realism. The first is that which is good for us, meets our needs rather than our wants. The second is, despite an individual's experience and background, an objective view of reality is probably true. We know it to be probably true because we compare it with our subjective reality that our common sense tells us is true. Lastly, we judge our personal views against reality using our natural powers of conception, judgment, and reason basing our decisions on available reason and evidence. Realism is a philosophical approach based on the acceptance of reality as is, which then is acted upon accordingly within the context of the client, the parameters of the system, and the universal lifeworld as it exists. It is embedded in reality and rejects the impractical.

The moderate realism conception of justice supports the thesis that "nurses must consider both perspectives (those subjective principles of both the nurse and the client) in light of objectively true principles related to the pursuit of happiness by human beings and must ground their nursing decisions in those principles."[3(p46)] To do otherwise would be unjust. The objectively held principles of justice central to moderate realism are natural needs, real goods, natural rights, and duties or moral obligations. According to the moderate realist conception, natural needs refer to those things in life we need, rather than want (ie, good health), and that are naturally good for us. Real goods are those goods that fill our needs rather than our wants (ie, water). Natural rights are those rights that we have by virtue of our humanness, rather than a legal right, for example the right to life, freedom, and dignity. Duties or moral obligations require us to act in a just and fair manner to ourselves and to others as we aspire to that which is good rather than evil or unjust. In order to make just decisions, knowledge of what is good for all humans is necessary, as well as

knowledge of what natural rights and moral obligations we ought to consider is necessary.

The underpinnings of moderate realism have potential to help us understand the complexities of decision-making by case managers and the dilemmas they face in the process. It legitimizes the practicality of their decision-making processes within the context of home care practice. The context of this practicality is situated in the interactions with clients and families usually within their homes. Case managers become knowledgeable, at times intimately so, about this environment, the place where families live, and where their priorities dominate. Case managers make their decisions in these personal places where control of activities lies with clients and their families, not with case managers. The decisions made by case managers, however, directly influence this personal domain of clients. It is this reality that creates the dilemmas inherent in the outcomes of those decisions. There is no nursing office or other private space for retreat to contemplate and review the information that has just been gathered. Case managers must quickly be able to recognize the resource limitations in the context of clients needs. Within this context, they must think sensibly and practically, as they make decisions "on their feet."

A comfortable fit seems to exist between these practical environments of home care case management and the common sense perspective of moderate realism. It is the practicality associated with making decisions within the domain of clients and their families combined with a framework of resource limitations where the common sense notion of moderate realism is particularly appealing. It is appealing not only because of its natural apparent fit within the context of case manager decision-making, but also because of its emphasis on sense-making and on the practicality of a given context. Practicality and sensibility are embedded within the context of home care and the case manager role within that context. Moderate realism, therefore, draws upon the practical nature of decision-making within the home care environment. It supports case managers in their frontline decision-making. It guides their decision-making so that the outcomes are just, benevolent, sensible, and sensitive to clients' values and wishes.

Another aspect of moderate realism that makes it an attractive perspective for home care is its position that common sense is unique and depends on an individual's life experience, perception, belief, and current reality. The notion of common sense is most evident in the negotiation process that occurs among clients, families, and case managers in their search for the appropriate levels of service. The dialogue of negotiation is a process where the two parties discuss their particular perspectives with a view to developing a common perspective acceptable to both. In the process a joint decision on a course of action is achieved.[3] Moderate realism indicates that case managers must consider both perspectives, ie, both client and nurse perspectives. Although feminism and critical theory also recognize the perspective of the client and the nurse, moderate realism promotes decisions that uphold those *objectively* held principles of natural needs, real goods, natural rights, and duties or moral obligations. Herein lies the edge that moderate realism offers to the home care context; while ensuring that objectively held principles are upheld, and just decisions are embedded within the situation.

It is within the principle of duty or moral obligation where the domain of justice is both within and beyond the individual client and is also within the realm of the system as it relates to the client. The decision must be fair for the client, and must also respect principles of distributive justice within the larger system. Case managers, in their decision-making, must secure the natural right of clients while operating within a system driven by an ideology cost containment and minimal acceptable service provision. To have enough resources so that all people in need will be able to secure those real goods to which they are entitled from the system is the justification for this minimalist belief. When case managers are required

to make difficult evenhanded decisions they are perhaps acting more from a justice rather than benevolent perspective. It is within the reality of case management practice that the principles of justice and the common good enter into all resource allocation decisions. In the spirit of justice and equity, individual need must be balanced with the common good in order that all clients in need receive adequate care. And it is the case manager who is caught in this tension between justice and benevolence. This tension intensifies because case managers are caught between their obligation to the individual clients they serve and their responsibility to society as a whole. The case managers desire to deliver excellent care on one hand must be countered with the general attitudes and values within society, such as the desire for lower taxation, that support the limitation of services.

Given the reality of these tensions, individual case managers carry enormous responsibility for the authorization of services and hence, the distribution of resources within home care programs. Yet, home care program administrators and policy-makers often believe that case managers make the best decisions about services because of the their intimate knowledge of client and family circumstances. This results in variation in the decisions made by case managers mentioned earlier in the article.

The decision-making processes within home care case management practice remain imperfect. Much work remains to be done in our efforts to reduce the imperfections and to advance greater consistency within the decision-making process. Our knowledge of the intricacies of the decision-making processes within case management practice is limited. It is our responsibility to reflect on the reasons for these imperfections so that greater understanding of the process can be achieved. Home care case managers will then have the opportunity to be more confident and competent in their decision-making. A moderate realist conception has the potential to "give traction to nursing action"[3(p52)] to enhance the decision-making process.

IMPLICATIONS FOR EDUCATION, PRACTICE, AND RESEARCH

If the expectation is that case managers are to be autonomous in their role and be responsible and accountable for the outcomes of client care then it is imperative that the issues raised in this article be addressed in the education, practice, and research related to case management. The realistic and practical perspective of moderate realism can inform us about the directions to take.

In education, colleges and universities are just recently offering formal courses in case management as substantive study content.[10] Although nursing faculties are beginning to respond to this case management knowledge gap, there remain many novice practitioners who have little understanding of the intricacies of case management practice. Kersbergen[9] reminds us that case management is here to stay and nursing education must be in touch with this reality. Content such as skill development in negotiation, delegation, outcome prediction and measurement, use of financial data and indicators, and cost analysis, traditionally presented mostly in business schools, must be included in nursing curricula. Practicum assignments or internships that place senior nursing students in environments where resource allocation decisions are made need to be encouraged. Such experiences could include practice with home care case managers or with the directors and senior executives in policy arenas.

In home care practice, educational opportunities for case managers to more fully understand their role, particularly in the area of resource allocation decision-making, need to be provided. Nurses must be given the tools that will allow them to perform in the case manager role with confidence and competence, to deal with the diversity, and to contextualize differences within home care practice. Case managers need confidence to know they will be supported in their decision-making by senior management when difficult choices have to made. Finally, there needs to be clear guidelines, appropriate policies, and adequate

education that will support the role of case managers in their resource allocation decisions.

Lastly, the implications for research are many. One area to be examined is the role of case management and its "fit" within the nursing discipline. To investigate this area might further illuminate the philosophical underpinnings of the nursing/case management duality in order to provide direction for education and practice of nurse case managers. Research into the effectiveness of nurses in case manager positions needs to be explored further. Specifically, how nurses engage in decision-making and resource allocation needs to be examined relative to other health professionals to determine differences and similarities. Finally, another vital area for future research is the examination of the evidence being used in resource allocation decision-making in terms of the nature and source of the evidence being used and how it is applied to decision-making processes.

CONCLUSION

With the growth of home care programs expected to continue, it is imperative that the issues related to decision-making within case management practice be addressed from a nursing perspective. Moderate realism[3] has provided a philosophical perspective that allows a practical interpretation of these issues. To inform case management practice from this practical common sense stance may help nurse case managers be more confident in their decision-making. They can be reassured that they are acting in a just and caring manner while meeting both the client-centered and the system-centered goals of case management practice.

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