

Ethical, Legal, and Economic Foundations of the Educational Process

M. Janice Nelson
Catherine V. Caldicott

CHAPTER HIGHLIGHTS

A Differentiated View of Ethics, Morality, and the Law

Evolution of Ethical and Legal Principles in Health Care

Application of Ethical Principles to Healthcare Education

Autonomy

Veracity

Confidentiality

Nonmaleficence

Beneficence

Justice

The Ethics of Education in Classroom and Practice Settings

The Student–Teacher Relationship

The Client–Provider Relationship

Legality in Healthcare Education and Information

Documentation

Economic Factors in Healthcare Education: Justice and Duty Revisited

Financial Terminology

Direct Costs

Indirect Costs

Cost Savings, Cost Benefit, and Cost Recovery Program Planning and Implementation

Cost-Benefit Analysis and Cost-Effectiveness Analysis

State of the Evidence

KEY TERMS

- ethics
- practice acts
- code of ethics
- autonomy
- decision aids
- veracity
- confidentiality
- nonmaleficence
- negligence
- malpractice
- beneficence
- justice

- | | |
|---|--|
| <input type="checkbox"/> direct costs | <input type="checkbox"/> cost recovery |
| <input type="checkbox"/> fixed costs | <input type="checkbox"/> revenue generation |
| <input type="checkbox"/> variable costs | <input type="checkbox"/> cost-benefit analysis |
| <input type="checkbox"/> indirect costs | <input type="checkbox"/> cost-benefit ratio |
| <input type="checkbox"/> cost savings | <input type="checkbox"/> cost-effectiveness analysis |
| <input type="checkbox"/> cost benefit | |

OBJECTIVES

After completing this chapter, the reader will be able to

1. Identify major ethical principles related to education in health care.
 2. Distinguish between ethical and legal dimensions of the healthcare delivery system with respect to patient and staff education.
 3. Describe the importance of practice acts and codes of ethics on the conduct of health professionals.
 4. Recognize the potential ethical consequences of power imbalances between the teacher and student or the health professional and patient in educational and practice settings.
 5. Describe the legal and financial implications of documentation.
 6. Delineate the ethical, legal, and economic importance of federal, state, and accrediting body regulations and standards in the delivery of healthcare services.
 7. Differentiate among financial terms associated with the development, implementation, and evaluation of patient education programs.
-

Approximately 40 years ago, the field of modern Western bioethics arose in response to the increasing complexity of medical care and decision making. Novel challenges in health care continually stem from such influences as technological advances, changes in laws, and public awareness of scientific endeavors. The field of bioethics provides systematic theoretical and practical approaches for handling such complex issues and the dilemmas that ensue. As a result, programs of study for health professionals now provide formal ethics education, some by mandate. Healthcare providers who commit ethical infractions while in training or practice

may be referred for ethics remediation by their programs or specialty licensing boards—or risk professional sanctions.

In the popular media, bioethics translates into stem cell research, organ transplantation, genetic testing, and other sensational innovations. But every day, far from the spotlight, healthcare students and clinicians confront commonplace and vexing ethical dilemmas. Consider a patient who refuses a routine but life-saving blood transfusion. Should she be allowed to refuse, or should health professionals persuade her otherwise? Or when a medical imaging technologist wheels an obviously confused elderly patient into the fluo-

roscopy suite for a swallowing study, should she ask whether the patient had enough decisional capacity to consent to the procedure? Dilemmas also arise in educational contexts. Suppose a surgeon misleads a family that a surgical error was really a “complication.” Should the cardiovascular perfusion student who observed the error speak up to a superior in the medical hierarchy? What about a physical therapy faculty member who habitually introduces a PT doctoral student to patients as “Dr.” Smith, implying that Ms. Smith has completed her doctoral training? Should the PT student correct her faculty member and, if so, when, where, and how?

These scenarios describe not only medical problems, but moral problems. They arise so frequently that convening the ethics committee is impractical. Increasingly, health professionals and their students must be able to reason through both medical and ethical issues. However, knowledge of basic ethical principles and concepts does not always suffice. As the healthcare field has developed, so has a critical consciousness of individual rights stemming from both natural and constitutional law. Healthcare organizations are laden with laws and regulations ensuring clients’ rights to a high-quality standard of care, to informed consent, and subsequently to self-determination. Further, in the interest of justice, it is worthwhile to acknowledge the relationship between costs to the healthcare facility and the provision of medical services. Consequently, it is crucial that the providers of care be equally proficient in educating both the public and health professions students—the practitioner educators of tomorrow.

This is an age of an enlightened public that is aware of and demands recognition of individual constitutional rights regarding freedom of choice and rights to self-determination. In fact, it may seem curious to some that federal and state governments, accrediting bodies, and professional organizations find it necessary to legislate, regulate,

or provide standards and guidelines to ensure the protection of human rights when it comes to matters of health care. The answer, of course, is that the federal government has abandoned its historical hands-off policy toward physicians and other health professionals in the wake of serious breaches of public confidence and shocking revelations of abuses of human rights in the name of biomedical research.

These issues of human rights are fundamental to the delivery of high-quality healthcare services. They are equally fundamental to the education process, in that the intent of the educator should be to empower the client to identify and articulate his or her values and preferences; acknowledge his or her role in a family, community, or other relationship; and to make well-informed choices, reasonably aware of the consequences of those choices. Thus, an explication of the role of the health professional in the teaching–learning process must include the ethical and legal foundations of that process. Teaching and learning principles, with their inherent legal and ethical dimensions, apply to any situation in which the educational process occurs.

The purpose of this chapter is to provide the ethical, legal, and economic foundations that underpin the patient education initiative, on the one hand, and the rights and responsibilities of the provider on the other. This chapter describes the differences between and among ethical, moral, and legal concepts. It explores the ethical and legal foundations of human rights, and it reviews the ethical and legal dimensions of health care. Furthermore, this chapter examines the importance of documentation of patient teaching while highlighting the economic factors that must be considered in the delivery of patient education in healthcare settings. An additional section provides a brief discussion of evidence-based practice and its relationship to quality and evaluation of patient education programs.

A Differentiated View of Ethics, Morality, and the Law

Although ethics as a branch of classical philosophy has been studied throughout the centuries, by and large these studies were left to the domains of philosophical and religious thinkers. More recently, because of the complexities of modern-day living and the heightened awareness of an educated public, ethical issues related to health care have surfaced as a major concern of both healthcare providers and recipients of these services. Thus, it is a widely held belief that the patient has the right to know his or her medical diagnosis, the treatments available, and the expected outcomes. This information is necessary so that patients can make informed choices relative to their respective diagnoses and treatments in concert with advice offered by health professionals.

Ethical principles that pertain to human rights are rooted in natural laws, which, in the absence of any other guidelines, are binding on human society. Inherent in these natural laws are, for example, the principles of respect for others, truth telling, honesty, and respect for life. Ethics as a discipline interprets these basic principles of behavior in broad terms that guide moral decision making in all realms of human activity (Tong, 2007).

Although multiple perspectives on the rightness or wrongness of human acts exist, among the most commonly referenced are the writings of the 16th-century German philosopher Immanuel Kant and those of the 19th-century English scholar and philosopher John Stuart Mill (Edward, 1967). Kant proposed that individual rights prevail and openly proclaimed the deontological notion of the “Golden Rule.” Deontology (from the Greek word *deon*, which means duty) is the ethical belief system that stresses the importance of doing one’s duty and following the rules. Thus, respect

for individual rights is key, and one person should never be treated merely as a means to another person’s benefit or a group’s well-being (Tong, 2007). Mill, on the other hand, proposed the teleological notion or utilitarian approach to ethical decision making that allows for the sacrifice of one or more individuals so that a group of people can benefit in some important way. He believed that given the alternatives, choices should be made that result in the greatest good for the greatest number of people.

Likewise, the legal system and its laws are based on ethical and moral principles that, through experience and over time, society has accepted as behavioral norms (Hall, 1996; Lesnick & Anderson, 1962). In fact, the terms *ethical*, *moral*, and *legal* are often used in synchrony. It should be made clear, however, that although these terms are certainly interrelated, they are not necessarily synonymous.

Ethics refers to the guiding principles of behavior, and *ethical* refers to norms or standards of behavior. Although the terms *moral* and *morality* are generally used interchangeably with the terms *ethics* and *ethical*, health professionals can differentiate the notion of moral rights and duties from the notion of ethical rights and duties. *Moral* refers to an internal value system (the moral fabric of one’s being) and this value system, defined as morality, is expressed externally through ethical behavior. Ethical principles deal with intangible moral values, so they are not enforceable by law, and neither are these principles laws in and of themselves. *Legal* rights and duties, on the other hand, refer to rules governing behavior or conduct that are enforceable under threat of punishment or penalty, such as a fine, imprisonment, or both.

The intricate relationship between ethics and the law explains why ethics terminology, such as informed consent, confidentiality, nonmaleficence, and justice, can be found within the language of the legal system. Health professionals

may cite professional commitment or moral obligation to justify the education of clients as one dimension of their role. In reality, the legitimacy of this role may also stem from the practice acts that exist in the particular state where the health professional resides, is licensed, and is employed. **Practice acts** are documents that define a profession, describe that profession's scope of practice, and provide guidelines for state professional boards regarding entry into a profession via licensure and disciplinary actions that can be taken when necessary. Practice acts were developed to protect the public from unqualified practitioners and to protect the professional title (e.g., RN, OT, RT). A *model practice act* serves as a template for individual states to follow to minimize variability from state to state within a profession. From the model, a state or other jurisdiction can develop its own practice act that addresses its particular needs in addition to including the basic information regarding scope of practice, licensure requirements, and so forth (Flook, 2003). In essence, a professional practice act is not only legally binding, but it is also protected by the police authority of the state in the interest of protecting the public (Brent, 2001; Mikos, 2004). **Table 2–1** lists various health professions' ethics codes and practice acts.

Evolution of Ethical and Legal Principles in Health Care

In the past, ethics was relegated almost exclusively to the philosophical and religious domains. Likewise, from a historical vantage point, medical and nursing care was considered a humanitarian, if not charitable, endeavor. Often it was provided by members of religious communities and others considered to be generous of spirit, caring in nature, courageous, dedicated, and self-sacrificing in their service to others. Public sentiment was so

strong in this regard that for many years health-care organizations, which were considered to be charitable institutions, were largely immune from legal action “because it would compel the charity to divert its funds for a purpose never intended” (Lesnik & Anderson, 1962, p. 211). In the same manner, healthcare practitioners in the past—who were primarily physicians and nurses—were usually regarded as Good Samaritans who acted in good faith.

Although there are numerous court records of lawsuits involving hospitals, physicians, and nurses dating back to the early 1900s, those numbers pale in comparison with the volumes being generated on a daily basis in today's world (Reising & Allen, 2007). Further, despite the horror stories that have been handed down through the years regarding inhumane and often torturous treatment of prisoners, the mentally infirm, the disabled, and the poor, there was limited focus in the past on ethical aspects of that care. In turn, there was little thought of legal protection for the rights of such mentally, physically, or socioeconomically challenged people.

Clearly, this situation has changed dramatically. For example, informed consent—a basic tenet of the ethical practice of health care—was established in the courts as early as 1914 by Justice Benjamin Cardozo. Cardozo determined that every adult of sound mind has a right to protect his or her own body and to determine how it shall be treated (Hall, 1992; *Schloendorff v. Society of New York Hospitals*, 1914). Although the Cardozo decision was of considerable magnitude, governmental interest in the bioethical underpinnings of human rights in the delivery of healthcare services did not really surface until after World War II.

Over the years, legal authorities such as federal and state governments maintained a hands-off posture when it came to issues of biomedical research or physician–patient relationships. However, human atrocities committed by the Nazis in

Table 2–1 HEALTH PROFESSIONS CODES OF ETHICS AND PRACTICE ACTS

Codes of Ethics	Practice Acts
Cardiovascular perfusion http://abcp.org/code_of_ethics.htm	Practice acts for some states only
Cytotechnology and lab technology http://www.amt1.com/files/Standards%20of%20Practice%20.pdf	Practice acts for some states only
Medical imaging http://www.medicalimaging.org/about/code.cfm	No practice act outside of medical practice act
Nursing http://nursingworld.org/ethics/code/protected_nwcoe813.htm	Practice act by state: http://www.the-travel-nurse.com/nursepracticeacts.html
Nutrition http://www.iaacn.org/CCN%20Code%20of%20Ethics%202005.pdf	Individual state practice acts and medical practice act
Occupational therapy http://www.aota.org/About/AboutOT/38527.aspx	Model practice act: http://www.aota.org/Practitioners/Advocacy/State/Resources/PracticeAct/36445.aspx
Pharmacy http://www.pharmacist.com/AM/Template.cfm?Section=Search1&template=/CM/HTMLDisplay.cfm&ContentID=2903	Model practice act: http://www.nabp.net/publications/assets/2009%20Model%20Act.doc
Physical therapy http://www.ptboard.state.az.us/public/ptays/docs/CodeofEthicsandGuide.pdf	Model Practice Act: https://www.fsbpt.org/RegulatoryTools/ModelPracticeAct/index.asp
Radiation therapy https://www.asrt.org/content/RTs/CodeofEthics/Therapy_CodeOfEthics.aspx	No practice act outside of medical practice act
Respiratory therapy http://www.aarc.org/resources/position_statements/ethics.html	Model practice act: http://www.aarc.org/advocacy/state/licensure.html (only available to members)
Social work http://www.socialworkers.org/pubs/code/code.asp	Model practice act: http://www.aswb.org/pdfs/Model_law.pdf

the name of biomedical research during World War II shocked the world into critical awareness of gross violations of human rights. Unfortunately, such abuses were not confined to wartime Europe. On U.S. soil, for example, the nontreatment of syphilitic African Americans in Tuskegee, Ala-

bama; the injection of live cancer cells into uninformed, nonconsenting older adults at the Brooklyn Chronic Disease Hospital; and the use of institutionalized mentally retarded children to study hepatitis at the Willowbrook State School on Staten Island, New York, shocked the nation and

raised a public awareness of disturbing breaches in the physician–patient relationship (Brent, 2001; Centers for Disease Control and Prevention, 2005; Rivera, 1972; Thomas & Quinn, 1991; Weisbard & Arras, 1984).

Stirred to action by these disturbing phenomena, in 1974 Congress moved with all due deliberation to create the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (U.S. Department of Health and Human Services [USDHHS], 1983). As an outcome of this unprecedented act, an institutional review board for the protection of human subjects (IRBPHS) was rapidly established at the local level by any hospital, academic medical center, agency, or organization where research on human subjects was being conducted. To this day, the primary function of these review boards is to safeguard all human study subjects by insisting that research protocols include voluntary participation and withdrawal, confidentiality, truth telling, and informed consent and address additional specific concerns for vulnerable populations such as infants, children, prisoners, and those with mental illnesses. Every proposal for biomedical research that involves human subjects must be submitted to a local IRBPHS for intensive review and approval before the proposed study proceeds (USDHHS, 1983). Further, in response to its concern about the range of ethical issues associated with medical practice and a perceived need to regulate biomedical research, Congress established in 1978 the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (Brent, 2001; Thomas & Quinn, 1991; USDHHS, 1983).

In addition, in 1975, the American Hospital Association (AHA) followed suit by disseminating a document titled *A Patient’s Bill of Rights*, which was revised in 1992 (Association of American Physicians and Surgeons, 1995). A copy of these patient rights is framed and posted in a public place in every healthcare facility across the United

States. In addition, federal standards developed by the Center for Medicare and Medicaid Services (CMS)—an arm of the Health Care Financing Administration (HCFA)—require that the patient be provided with a personal copy of these rights either at the time of admission to the hospital or long-term care facility or prior to the initiation of care or treatment when admitted to a surgicenter, HMO, home care, or hospice. As a matter of fact, many states have adopted the statement of patient rights as part of their state health code. Thus, these rights fall under the jurisdiction of the law, rendering them legally enforceable by threat of penalty.

But did the professions themselves speak up in the face of the outrageous violations of human rights in the name of research? Indeed, two professional groups acted well before the 1970s to establish uniform standards for professional training and conduct. The first was the American Medical Association (AMA), which wrote and published its Code of Medical Ethics in 1847. Renamed *The Principles of Medical Ethics* in 1903, the code is currently in its fifth revision (AMA, 2001). All five versions address the precedence of patients’ welfare and physicians’ moral rectitude over scientific accomplishment and professional gain. Despite such regular attention to the values to which physicians commit themselves individually and collectively, the preceding historical examples attest to a disconnect between espoused values and actual practice, a failure of widespread individual and collective professional accountability.

In 1950, the American Nurses Association (ANA) developed and adopted an ethical code for professional practice that has since been revised and updated several times (ANA, 1976, 1985, 2001). The latest revision of the ANA’s code, now titled the *Code of Ethics for Nurses With Interpretive Statements*, was released in 2001 for implementation in the new millennium. This **code of ethics** represents an articulation of professional values and moral obligations in relation to the nurse–patient

relationship and in support of the profession and its mission. Although other health professions have adopted their own codes of ethics (as identified in Table 2–1), the nursing profession’s code has been recognized as exemplary and has been used as a template by other health discipline organizations in the crafting of their own ethics documents.

Health professional organizations have accepted the responsibility for establishing standards of ethical behavior for members of their disciplines in the context of health care practice. In the end, however, it is up to the individual nurse, respiratory therapist, social worker, ultrasonographer, or other health professional to take his or her professional ethics code to heart. The following portion of this chapter addresses the application of ethical and legal principles and concepts by individual health professionals to their clients.

Application of Ethical Principles to Healthcare Education

Various theories and traditions can frame a health professional’s understanding of the ethical dimensions in the healthcare setting. In considering the ethical and legal responsibilities inherent in the process of patient education, healthcare professionals and students can turn to a framework of six major ethical principles—including the so-called big four principles initially proposed by Beauchamp and Childress (1977)—that are intricately woven throughout the ANA’s *Code of Ethics* (2001), the AHA’s *A Patient’s Bill of Rights* (1992), and similar documents promulgated by other healthcare organizations as well as the federal government. These principles, which encompass the very issues that precipitated federal intervention into healthcare affairs, are autonomy, veracity, confidentiality, nonmaleficence, beneficence, and justice.

Autonomy

The term **autonomy** is derived from the Greek words *auto* (self) and *nomos* (law) and refers to the right of self-determination (Tong, 2007). Laws have been enacted to protect the patient’s right to make choices independently. Federal mandates, such as informed consent, must be evident in every application for federal funding to support biomedical research. The local IRBPHS assumes the role of judge and jury to ascertain adherence to this enforceable regulation (Dickey, 2006).

The Patient Self-Determination Act (PSDA), which was passed by Congress in 1991 (Ulrich, 1999), is a clear example of the principle of autonomy enacted into law. Any healthcare facility, such as acute- and long-term care institutions, surgicenters, HMOs, hospices, or home care, that receives Medicare and/or Medicaid funds must comply with the PSDA. The law requires, either at the time of hospital admission or prior to the initiation of care or treatment in a community health setting, “that every individual receiving health care be informed in writing of the right under state law to make decisions about his or her health care, including the right to refuse medical and surgical care and the right to initiate advance directives” (Mezey, Evans, Golob, Murphy, & White, 1994, p. 30). Although ultimate responsibility for discussing treatment options and a plan of care and obtaining informed consent rests with the physician, these authors readily acknowledge the nurse’s responsibility to ensure informed decision making by patients, which includes but is certainly not limited to advance directives (e.g., living wills, durable power of attorney for health care, and designation of a healthcare agent). Evidence of such instruction must appear in the patient’s record, which is the legal document validating that informed consent took place.

One principle worth noting in the ANA’s *Code of Ethics* is that which addresses collaboration “with members of the health professions and other citi-

zens in promoting community and national efforts to meet the health needs of the public” (New York State Nurses Association, 2001, p. 6). Similarly, the American Physical Therapy Association’s *Code of Ethics* states in Principle 8, “A physical therapist shall provide and make available accurate and relevant information to patients/clients about their care and to the public about physical therapy services” (Federation of State Boards of Physical Therapy, 2006). These principles provide justification for patient education both within and outside the healthcare organization. Although health education, per se, is not an interpretive part of the principle of autonomy, it certainly lends credence to the ethical notion of assisting the public to attain greater autonomy when it comes to matters of health promotion and high-level wellness. In fact, the practice acts for nursing, occupational therapy, physical therapy, and respiratory care list patient education as within their scopes of practice. Even though other healthcare-related practice acts are not explicit on this point, many health professionals consider patient education a means of demonstrating their commitment to patient welfare, trustworthiness, and informed decision making.

An additional moral framework through which to view the practice of patient education is a framework of expansion of patient capabilities (Redman, 2008). The reason to view expansion of capabilities as a moral enterprise is that capabilities of, say, healthfulness, self-care, engaging in life, relationships, and pursuits, “have value in themselves and are of special importance in making possible any choice of a way of life” (p. 815).

Another example of autonomy is the development and use of patient decision aid interventions designed to assist clients to make informed treatment choices (Bekker, 2010). These patient **decision aids**, which include printed materials, videos, and interactive Web-based tutorials, provide clients with information about specific health issues, particular diagnoses, treatment risks and

benefits, and questionnaires to determine whether clients need more information. “The emphasis on collaboration between providers and patients on decision making has, in turn, stimulated the development of tools to help patients and their families participate in clinical discussions and reach decisions that incorporate personal values and goals” (Wittmann-Price & Fisher, 2009).

Veracity

Veracity, or truth telling, is closely linked to informed decision making and informed consent. The early-20th-century landmark decision by Justice Benjamin Cardozo (*Schloendorff v. Society of New York Hospitals*, 1914) specifies an individual’s fundamental right to make decisions about his or her own body. This ruling provides a basis in law for patient education or instruction regarding invasive medical procedures. Nurses are often confronted with issues of truth telling, as was exemplified in the *Tuma* case (Rankin & Stallings, 1990). In the interest of full disclosure of information, the nurse (Tuma) had advised a cancer patient of alternative treatments without consultation with the client’s physician. Tuma was sued by the physician for interfering with the medical regimen that he had prescribed for care of this particular patient. Although Tuma was eventually exonerated from professional misconduct charges, the case emphasizes a significant point of law to be found in the New York State Nurse Practice Act (New York State Nurses Association, 1972), which states, “A nursing regimen shall be consistent with and shall not vary from any existing medical regimen.” However, others insist that failure to instruct the patient properly relative to invasive procedures is tantamount to battery (Creighton, 1986). Therefore, in some instances, the health professional may find himself or herself in a double bind. If in such a dilemma, the health professional has a variety of actions available. Two possibilities would be to inform the physician of the professional double

bind and engage with him or her in achieving a course of action that best meets the patient's medical needs while respecting the patient's autonomy; and to seek out the institutional ethics committee or an ethics consultant for assistance in negotiating interactions with both the physician and the patient.

Cisar and Bell (1995) address this concept of battery related to medical treatment and offer the following explanation of the four elements making up the notion of informed consent that are such vital aspects of patient education:

1. *Competence*, which refers to the capacity of the patient to make a reasonable decision.
2. *Disclosure of information*, which requires that sufficient information regarding risks and alternative treatments—including no treatment at all—be provided to the patient to enable him or her to make a rational decision.
3. *Comprehension*, which speaks to the individual's ability to understand or to grasp intellectually the information being provided. A child, for example, may not yet be of an age to understand any ramifications of medical treatment and must, therefore, depend on his or her parents to make a decision that will be in the child's best interest. Similarly, for an adequate informed consent conversation, all options must be expressed in a language the patient can understand and in lay terms.
4. *Voluntariness*, which indicates that the patient has made a decision without coercion or force from others.

Although all four of these elements might be satisfied, the patient might still choose to reject the regimen of care suggested by healthcare providers. This decision could be the result of the exorbitant cost of a treatment or certain personal or religious beliefs. Whatever the case, it must be recognized by all concerned that a competent, informed client cannot be forced to accept treatment as long as he or she is aware of the alternatives as well as

the consequences of any decision (Cisar & Bell, 1995).

Finally, a dimension of the legality of truth telling relates to the role of the health professional as expert witness. Health professionals who are recognized for their skill or expertise in a particular area of practice may be called on to testify in court on behalf of either the plaintiff (the one who initiates the litigation) or the defendant (the one being sued). In any case, the concept of expert testimony speaks for itself. Regardless of the situation, the health professional must always tell the truth and the patient (or his or her healthcare agent) is always entitled to the truth (Hall, 1996).

Confidentiality

Confidentiality refers to personal information that is entrusted and protected as privileged information via a social contract, healthcare standard or code, or legal covenant. When acquired in a professional capacity from a patient, healthcare providers may not disclose such information without consent of that patient. If sensitive information were not to be protected, patients would lose trust in their providers and would be reluctant to openly share problems with them or even seek medical care at all.

A distinction must be made between the terms *anonymous* and *confidential*. Information is *anonymous*, for example, when researchers are unable to link any subject's identity in the medical record of that person. Information is *confidential* when identifying materials appear on subjects' records but can be accessed only by the researchers (Tong, 2007).

Only under special circumstances may secrecy be ethically broken, such as when a patient has been the victim or subject of a crime to which the health professional is a witness (Lesnick & Anderson, 1962). Other exceptions to confidentiality occur when health professionals suspect or are aware of child or elder abuse, narcotic use,

legally reportable communicable diseases, gunshot or knife wounds, or the threat of violence toward someone. To protect others from bodily harm, health professionals are legally permitted to breach confidentiality.

In the case of communicable diseases, patients should not be forced or coerced to name their contacts, again because respecting confidentiality maintains trust between the patient and health professional. But is it fair to deprive a vulnerable spouse or contact of this important health information? Is it morally acceptable to put one person's rights above those of another? In some situations, yes, although these decisions are best considered after much deliberation with the patient and other trusted health professionals. Of course, if a patient discloses the identity of his or her contacts, health professionals are mandated to inform them in accordance with applicable state laws. But if a patient tests positive for HIV/AIDS, for example, and has no intention of telling his or her spouse about this diagnosis, the physician has an obligation to warn the spouse directly or indirectly (i.e., through anonymous lab reporting) of the risk of potential harm (Tong, 2007). Adequate deliberation with the patient and others can reveal circumstances in which the reality is even more complex. For example, if the physician or other primary healthcare provider explores the patient's rationale for not wanting to inform his or her spouse of the infectious disease status, it may be out of fear of inciting domestic violence. According to Brent (2001), "this area of legislation concerned with health care privacy and disclosure reveals the tension between what is good for the individual vis-à-vis what is good for society" (p. 141).

The 2003 updated Health Insurance Portability and Accountability Act (HIPAA) ensures nearly absolute confidentiality related to dissemination of client information, unless the client himself or herself authorizes release of such information (Kohlenberg, 2006). One goal of the HIPAA policy, first enacted by Congress in 1996, is to

limit disclosure of patient healthcare information to third parties, such as insurance companies or employers. This law, which requires patients' prior written consent for release of their health information, was never meant to interfere with consultation between professionals, but is intended to prevent, for example, elevator conversations about private matters of individuals entrusted to the care of health professionals. In a technologically advanced society such as exists in the United States today, this law is a must to ensure confidentiality (Tong, 2007). Currently, in some states and under certain conditions, such as death or impending death, a spouse or members of the immediate family can be apprised of the patient's condition if this information was previously unknown to them. Despite federal and state legislation protecting the confidentiality rights of individuals, the issue of the ethical/moral obligation of the patient with HIV/AIDS or genetic disease, for example, to voluntarily divulge his or her condition to others who may be at risk remains largely unresolved (Legal Action Center, 2001).

Nonmaleficence

Nonmaleficence means "do no harm" and constitutes the ethical fabric of legal determinations encompassing negligence and/or malpractice. According to Brent (2001), **negligence** is defined as "conduct which falls below the standard established by law for the protection of others against unreasonable risk of harm" (p. 54). She further asserts that the concept of professional negligence "involves the conduct of professionals (e.g., nurses, physicians, dentists, and lawyers) that fall [*sic*] below a professional standard of due care" (p. 55). As clarified by Tong (2007), due care is "the kind of care healthcare professionals give patients when they treat them attentively and vigilantly so as to avoid mistakes" (p. 25). For negligence to exist, there must be a duty between the injured party and the person whose actions (or nonactions) caused

the injury. A breach of that duty must have occurred, it must have been the immediate cause of the injury, and the injured party must have experienced damages from the injury (Brent, 2001).

The term **malpractice**, by comparison, still holds as defined by Lesnick and Anderson in 1962. Malpractice, these authors assert, “refers to a limited class of negligent activities committed within the scope of performance by those pursuing a particular profession involving highly skilled and technical services” (p. 234). More recently, malpractice has been specifically defined as “negligence, misconduct, or breach of duty by a professional person that results in injury or damage to a patient” (Reising & Allen, 2007). Thus, malpractice, per se, is limited in scope to those whose life work requires special education and training as dictated by specific educational standards. In contrast, negligence embraces all improper and wrongful conduct by anyone arising out of any activity. Reising and Allen (2007) describe the most common causes for malpractice claims specifically against nurses, but these causes are also relevant to the conduct of other health professionals within the scope of their practice responsibilities:

1. Failure to follow standards of care
2. Failure to use equipment in a responsible manner
3. Failure to communicate
4. Failure to document
5. Failure to assess and monitor
6. Failure to act as patient advocate
7. Failure to delegate tasks properly

The concept of duty is closely tied to the concepts of negligence and malpractice. Health professionals’ duties are spelled out in job descriptions at their places of employment. Policy and procedure manuals of a particular facility exist certainly to protect the patient and ensure good quality care, but they also exist to protect the employee and the employer against litigation. Policies are more than

guidelines. Policies and procedures determine standards of behavior (duties) expected of employees of a particular institution and can be used in a court of law in the determination of negligence.

Health professionals’ moral duties are the things that they ought to do or the way they ought to behave in a healthcare situation with ethical import. So, for example, imagine a laboratory technician notices a blood specimen labeled with a neighbor’s name and birth date. The technician’s duty is to respect or maintain patient confidentiality no matter how much he or she might want to look up the results of the tests (if a different technician ran them) or share the results with others. Even if the technician ran the test and is therefore privy to the results, and chooses to share the results only with the patient, the technician violates the standard practice regarding who has the right and responsibility to inform the patient of test results. In either case, the lab technician breaks confidentiality, violates his or her duty to maintain patient privacy, oversteps his or her professional role, and potentially erodes trust in the medical profession.

Expectations of healthcare providers’ performance are also measured against each professional’s level of education and concomitant skills, standing orders of the physician, institution-specific protocols, standards of care upheld by the profession, and standards of care adhered to by any subspecialty organizations of which the health professional may be a member. If, for example, a nurse is certified in a clinical specialty or is identified as a “specialist” although not certified, he or she will be held to the standards of that specialty (Yoder Wise, 1995).

In the instance of litigation, the key operational principle is that the health professional is not measured against the optimal or maximum of professional standards of performance; rather, the yardstick is laid against the prevailing practice of what a prudent and reasonable professional in that healthcare field would do under the same circumstances in a given community. Thus, a health

professional's duty of patient education (or lack thereof) is measured against not only the prevailing policy of the employing institution, but also against prevailing practice in the community. For example, the social worker's, nutritionist's, or pharmacist's practice is measured against institutional policies for this level of worker as well as against the prevailing practice of these professionals performing at the same level in the community or in the same geographic region.

Beneficence

Beneficence is defined as “doing good” for the benefit of others. It is a concept that is legalized through adherence to critical tasks and duties contained in job descriptions; in policies, procedures, and protocols set forth by the healthcare facility; and in standards and codes of ethical behaviors established by health professional organizations. Adherence to these various professional performance criteria and principles, including adequate and current patient education, speaks to the health professional's commitment to acting in the best interest of the patient. Sometimes health professionals, such as radiation therapists and mammographers, are called upon to treat patients in ways that cause physical discomfort or harm. Although difficult, these professionals do their jobs because the patients believe that the treatments will, on balance, benefit them.

Unlike principles such as autonomy and veracity that are most directly applicable to health professionals who interact with patients, beneficence applies to the work of the full range of healthcare providers. Maintaining technical competence; attending to quality checks; being punctual, prepared, and attentive; and holding self and peers accountable to performance standards all demonstrate a commitment to benefiting the patient.

But in the clinical realm, a health professional's demonstration of beneficence is not always as

simple as adherence to tasks, duties, and practice guidelines. Patients may not desire the recommended therapy or may introduce other considerations that make it difficult to follow protocols. The relationship between a health professional and a patient is described as *fiduciary*—characterized by trust. The client trusts that the health professional will act in the client's best interest and, if necessary, will subordinate self-interest. Should the X-ray technician go on a scheduled break when a backlog of patients waits to have their films taken? The X-ray technician may be tired or hungry, but patients' best interests nearly always trump the interests of others. If the technician is so overdue for a break that hunger or fatigue impair his or her ability to function competently, then of course patients' interests are better served if the technician goes on break. Patients trust that the healthcare provider will balance potential harms against benefits to make a decision about how to act ultimately in the patient's best interest.

But is it morally acceptable—or even expected—that health professionals put client benefit ahead of their own well-being? The effort to save lives and relieve human suffering is a duty to do good only within reasonable limits. For example, when AIDS first appeared, the cause and control of this fatal disease were unknown. Some health professionals protested that the duty of beneficence did not include caring for patients who put them at risk for this deadly, infectious, and untreatable disease. Others maintained that part of the decision to become a health professional involves the acceptance of certain personal risks: It is part of the job. Nevertheless, once it became clear that HIV transmission through occupational exposure was quite small, the majority of healthcare practitioners concurred with the opinion of the American Medical Association that they “may not ethically refuse to treat a patient whose condition is within [their] current realm of competence solely because the patient is seropositive” (Tong, 2007).

Justice

Justice speaks to fairness and the equitable distribution of goods and services. The law is the justice system. The focus of the law is the protection of society; the focus of health law is the protection of the consumer. It is unjust to treat a person better or worse than another person in a similar condition or circumstance, unless a difference in treatment can be justified with good reason. In today's healthcare climate, professionals must be as objective as possible in allocating scarce medical resources in a just manner. Decision making for the fair distribution of resources includes the following criteria as defined by Tong (2007):

1. To each, an equal share
2. To each, according to need
3. To each, according to effort
4. To each, according to contribution
5. To each, according to merit
6. To each, according to the ability to pay (p. 30)

According to Tong (2007), health professionals may have second thoughts about the application of these criteria in particular circumstances because one or more of the criteria could be at odds with the concept of justice. "To allocate scarce resources to patients on the basis of their social worth, moral goodness, or economic condition rather than on the basis of their medical condition is more often than not wrong" (p. 30).

As noted earlier, adherence to *A Patient's Bill of Rights* is legally enforced in most states. This means that any health professional can be subjected to penalty or to litigation for discrimination in provision of care. Regardless of his or her age, gender, physical disability, sexual orientation, or race, for example, the client has a right to proper instruction regarding risks and benefits of invasive medical procedures. She or he also has a right to proper instruction regarding self-care activities, such as home dialysis, for example, that are beyond normal activities of daily living for most people.

Furthermore, when a health professional is employed by a particular healthcare facility, she or he enters into a contract, written or tacit, to provide services in accordance with the policies of the facility. Failure to provide health care (including educational services) based on patient diagnosis or persistence in providing substandard care based on client age, diagnosis, culture, national origin, sexual preference, and the like can result in liability for breach of contract with the employing institution.

In 1986, it became illegal for virtually every U.S. hospital to deny emergency evaluation and treatment to patients solely based on their ability to pay. Called the Emergency Medical Treatment and Active Labor Act (EMTALA), this federal legislation prohibits hospitals from rejecting or "dumping" uninsured patients or those covered by Medicare or Medicaid on "charity" or county hospitals (Consolidated Omnibus Budget Reconciliation Act of 1985). In other words, all patients who present with an emergency medical condition (or in active labor) must be treated in the same way, regardless of insurance status.

But uninsured and Medicare and Medicaid patients are still subject to other, more subtle discrimination. Because many outpatient facilities do not accept these patients, this restriction on their right of access to health care extends to their right to access health education. Emanuel (2000) raises a critical point in asserting that "the diffuseness of decision making in the American health care system precludes a coherent process for allocating health care resources" (p. 8). Emanuel further contends that managed care organizations have systematically pursued drastic cost reductions by restructuring delivery systems and investing in expensive and elaborate information systems. HMOs have bought out physician practices and have become involved in a number of related activities with no substantial evidence that a high quality of health care will be achieved at lower prices.

These issues determine whether health educators can surmount the obstacles potentially blocking the patient education process. In the interest of cutting costs, HMOs have also succeeded in shortening lengths of hospital stays. This development, in turn, has had a tremendous effect on the delivery of education to the hospitalized patient and presents serious obstacles to the implementation of this mandate. Lack of time serves as a major barrier to the nurse's or other health professional's ability to give discharge instructions that contain sufficient information for self-care. Also, illness acuity level interferes with the patient's ability to process information necessary to meet his or her physical and emotional needs.

Nurses and occupational, physical, and respiratory therapists are mandated by organizational policy as well as by federal and state regulations (for example, practice acts) to provide client education. Thus, great care must be taken to ensure that the education justly due to the patient will be addressed post discharge, either in the ambulatory care setting, at home, or in the physician's office.

The Ethics of Education in Classroom and Practice Settings

The Student–Teacher Relationship

Many of the foundational principles and concepts of ethics that apply to client care also apply to questions of what ought to be done or how health professionals ought to behave in the education of students for the health professions. Students and teachers have their own perspectives, visions, values, and preferences that are unknown to each other. These two worldviews come together in the classroom. They must be negotiated and understood by each party for the process of education and training to proceed with trust and respect (Freedman, 2003).

A balance of power exists between the teacher (expert) and student (novice). The teacher possesses discipline-specific expertise, which is key to the student's academic success, career achievement, and competent care of patients. Students must be able to trust their teachers—even instantaneously—that the instruction will be accurate, appropriate, and up-to-date. Students have a right to assume their instructors are competent and employ that competence in the best interests of the students and the particular health profession.

Another area of ethical import inherent in student–teacher relationships is the potential blurring of professional–personal boundaries. Students experience personal difficulties that can interfere with their studies or with their goals in pursuing a degree in the health professions. If the nature of the student's concerns is outside pedagogic goals, how should the teacher respond? In such a case, the ethics of the situation applies not to the process of education itself but to two individuals who happen to know each other because of an educational context. This distinction is important. Whereas sometimes teachers are called upon to serve as advisors for students, typically the advice pertains to professional training matters. However, a teacher may be approached because he or she is known to the student and is trustworthy in a classroom context, but the issue at hand requires counseling of a noneducational nature. In such a case, the teacher is expected to address openly and honestly with the student the potential consequences to their student–teacher relationship of discussing personal issues (Ewashen & Lane, 2007).

Educators can use the following specific criteria to distinguish between interactions that are appropriate in the context of the educational process and those that are less appropriate or even frankly inappropriate (Martinez, 2000):

- Risk of harm to the student or to the student–teacher relationship
- Presence of coercion or exploitation

- Potential benefit to the student or to the student–teacher relationship
- Balance of student’s interests and teacher’s interests
- Presence of professional ideals

These five criteria can assist the teacher in being fully honest with him- or herself regarding the appropriateness of counseling the student and can serve as an extremely useful guide in uncertain situations.

Students are autonomous agents. If they choose to follow the prescribed course of study and are successful, they will develop professional autonomy, attain their professional goals, achieve professional competence, and be equipped to develop relationships with colleagues and patients. Students in disciplines such as cytotechnology or laboratory technology, who do not have direct patient care responsibilities but who will spend their careers in a laboratory, also have a fiduciary relationship to the patients whose diagnoses, treatments, and future lives depend on the accurate examination of tissues and other specimens.

Students are responsible for speaking up when they experience problems with or obstacles to their learning. Otherwise their teachers may make overly ambitious demands on and expectations for students in the learning process. Just as students have a right to expect honesty from their teachers, they have a reciprocal duty to be truthful as well—such as when they have not done an assignment or prepared for a class activity, or have made a mistake. In addition, truthfulness affects a vulnerable third party: the patient whose care is at the hands of the student. Taking responsibility for one’s missteps as a student reveals the student’s commitment to honesty, the primacy of patient welfare, and trustworthiness (Reiser, 1994).

Sometimes students in the health professions also decide to shield their instructors from the complexities of their patients’ situations. Perhaps students want to help their patients appear as

“good” as possible. Or, perhaps motivated by a desire to get a good evaluation themselves and avoid descriptors such as “difficult,” “took up too much time with details,” or “not a team player,” students may select what they believe their instructors will want to deal with. One student who was following a postsurgical patient remarked, “[I]n bringing up my patient’s [sore] throat, I was also wasting precious time . . . , and so I learned to keep quiet about his complaints” (Zucker, 2009). By acting in this way, students place their *perceptions* of their instructors’ needs before the needs of their patients, at a time when the students are trying to learn exactly which bona fide medical needs should legitimately assume priority over others. Who else but instructors can most effectively assist students to learn how to prioritize among competing patient concerns? Yet how can instructors perform this important component of their jobs if they are hearing a censored rendition of those concerns?

By trying to appear “good” and restrict the range and depth of concerns patients bring to their health professionals, students may undermine the reciprocity of the healthcare provider–patient relationship. Without an explicitly bidirectional education model, patients may be reluctant to voice all their concerns, reservations, and questions about a proposed recommendation or treatment.

In addition, consider the ethical import of the transience of many student–teacher relationships (Christakis & Feudtner, 1997). The systems of health professions education create communities of relative strangers. For example, a respiratory therapy student may conflate trust with authority when a visiting professor teaches a core course in the curriculum. Although the visiting professor may be a renowned authority on lung mechanics, she may be authoritarian in the classroom, a poor exemplar of putting the student’s educational needs foremost. The student may deferentially endure the class, knowing that sooner or later it will end and the professor will return to her home institution. The poor learning climate discourages

any reciprocity of concern or trust, impedes the student's professional development, and deprives the professor of valuable opportunities to demonstrate humility before the students.

Students rely on their teachers to be role models and mentors. They observe how teachers hold themselves and other instructors accountable to honest and conscientious practice standards. They witness how teachers treat students and colleagues. Such teacher behaviors exemplify instruction in a relational context: Technical information is interwoven with role modeling. From these observations, students receive lessons that assist them in developing and establishing habits of interaction with coworkers, patients, and, if they become educators themselves, their own future students (Reiser, 1993).

The Client–Provider Relationship

Health professionals (and health professions students) and the clients they care for also have their own worldviews that come together in the practice setting. These perspectives must be negotiated and understood by each party for the process of patient education to occur with a sense of trust. Many types of health professionals have limited or no direct patient contact that would involve patient education, such as cardiovascular perfusion, laboratory, and medical imaging technologists. Nevertheless, the following discussion may be helpful to them as they reflect on their attitudes regarding patient responsibilities for self-care, disease prevention, and adhering to medical recommendations (i.e., compliance).

As with the student–teacher relationship, it is important to recognize the balance of power that exists between a health professional—and even a health professions student—and a patient. The health professional possesses medical expertise—keys to the patient's health, well-being, and ability to work, play, go to school, or engage in social relationships. For those reasons, the ethics of being

a patient typically includes respecting health professionals and trusting them to have the patient's best interests at heart. Patients have a moral claim on the health professional's competence and on the use of that competence for the patient's welfare (Pellegrino, 1993).

The blurring of professional–personal boundaries is also an area of ethical import common to health professional (or health professions student)–patient relationships. The potential for blurred boundaries between professionals and clients is particularly evident because of the intimacies of the practice setting. Patient education can take place when patients are wearing little clothing, are lying down in a bed, are sharing personal information with the health professional, or are in the context of medically related physical contact. Again, the five criteria noted earlier in the students and teachers section (Martinez, 2000) are relevant. Simply substitute the word *patient* or *client* for *student* to see how these criteria can assist in distinguishing between interactions that are acceptable in the context of the practice setting and those that are less acceptable or even frankly unacceptable. Health professionals are obligated to remain mindful of the power imbalance between them and patients, to put the patient's welfare before their own concerns, and to reflect honestly on the consequences of blurred boundaries to the patient and to their relationship with the patient in the practice setting.

Out of a respect for patient autonomy, a model of medical decision making shared between health professional and patient has assumed primacy in various health communication curricula and practices (deBocanegra & Gany, 2004; Donetto, 2010; Visser, 1998). This model supports imparting health-related information selected by the health professional to the patient for the purposes of the patient making his or her choices and preferences known. Health professionals engaging in this process may be well-meaning. Nevertheless, the unidirectional nature of this model of patient

education succeeds in reinforcing the power that health professionals have over patients by virtue of their technical knowledge.

Health professions students may be particularly inclined to rely on a largely information-dissemination method of educating patients. This is understandable during the formative years of their training when they are beginning to appreciate and employ their own technical knowledge. Inevitably, such a reductionistic conception of patient education will bump up against real practice situations in which the complexity of individual patients' circumstances will demand a more reciprocal model of education (Donetto, 2010).

Similar to students, patients are autonomous agents. They may choose to follow the recommended course of treatment because they trust their health professional and believe that what has been recommended will improve their condition. They may also follow recommendations because they understand the rationale for the treatment, they consider the treatment is acceptable or at least tolerable, the treatment fits into their lifestyle and worldview, they can afford it financially, and for many other reasons.

Furthermore, some patients believe that they should behave like "good" patients by taking all medications or doing all exercises as prescribed, adhering to a recommended diet, not complaining, and so forth, so that their health professional will like them, consider them worthy of their time, and want to continue to take care of them (Buckwalter, 2007; Freedman, 2003). This desire to be a "good" patient underscores how dependent and vulnerable patients can feel. Even when presenting for a screening mammogram or follow-up urine culture, patients are not at their best. At every medical encounter there exists the potential for discovering something that merits concern.

In the practice setting, it is plausible that a nurse providing discharge instructions to a patient may not necessarily give the patient a fair share of his or her time or be open to all the patient's ques-

tions if the nurse knows he or she will never see that patient again. Admittedly, the better the patient education, the longer he or she likely will remain out of the hospital. However, if the nurse is extremely busy with other competing priorities or is tired from having worked two shifts in a row, he or she may not reflect on how fatigue or work demands precipitate a failure to focus primarily on this particular patient's welfare. It may be easier for the nurse to assume a "let someone else deal with it" attitude. Similarly, a laboratory technician providing instructions to a patient about doing a 24-hour urine collection or an oral glucose tolerance test may not be inclined to hold himself or herself accountable to give the instructions clearly and carefully to someone he or she may never encounter again. Transient relationships facilitate a lack of focus on the welfare, time, and interests of each patient.

Legality in Healthcare Education and Information

The patient's right to adequate information regarding his or her physical condition, medications, risks, and access to information regarding alternative treatments is specifically spelled out in various renditions of *A Patient's Bill of Rights* (AHA, 1992; ANA, 2001; Association of American Physicians and Surgeons, 1995; President's Advisory Commission, 1998). As noted earlier, many states have adopted these rights as part of their health code, thus rendering them legal and enforceable by law. Patients' rights to education and information are also regulated through standards promulgated by accrediting bodies such as the Joint Commission (JC), formerly known as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Although these standards are not enforceable in the same manner as law, lack of organizational conformity can lead to loss of accreditation, which in turn jeopardizes the facility's

eligibility for third-party reimbursement, as well as loss of Medicare and Medicaid reimbursement. Lack of organizational conformity can also lead to loss of public confidence.

In addition, state regulations pertaining to patient education are published and enforced under threat of penalty (fine, citation, or both) by the department of health in many states. Federal regulations, enforceable as laws, also mandate patient education in those healthcare facilities receiving Medicare and Medicaid funding. And, as discussed earlier, the federal government also mandates full patient disclosure in cases of participation in biomedical research in any setting or for any federally funded project or experimental research involving human subjects.

It should be noted that the AHA's 1975 original draft rendition of *A Patient's Bill of Rights*, along with all the later renditions of these rights, is linked to or associated with every ethical principle. *A Patient's Bill of Rights* (AHA, 1992) is rooted in the conditions of participation in Medicare set forth under federal standards established by the Centers for Medicare and Medicaid Services (CMS). Corresponding accreditation standards promulgated by the JC further emphasize these standards. All these laws and professional standards serve to ensure the fundamental rights of every person as a consumer of healthcare services. **Table 2–2** is a visual representation of the relationship of ethical principles to the laws and professional standards applicable to each principle.

Federal authorities have generally tended to hold physicians responsible and accountable for proper patient education. However, often the nurse or some other physician-appointed designee carries out patient education. Physicians' responsibility notwithstanding, "patient education is central to the culture of nursing as well as to its legal practice" (Redman, 2008) by virtue of respective state nurse practice acts. The same can be said for the practice acts governing occupational, physical, and respiratory therapists, for example.

Documentation

The 89th Congress enacted the Comprehensive Health Planning Act in 1965, Public Law 89-97, 1965 (Boyd, Gleit, Graham, & Whitman, 1998). The entitlements of Medicare and Medicaid—which revolutionized the provision of health care for older adults and people who are socioeconomically deprived—were established through this act. One acknowledgment in the act was the importance of the preventive and rehabilitative dimensions of health care. Thus, to qualify for Medicare and Medicaid reimbursement, "a hospital has to show evidence that patient education has been a part of patient care" (Boyd et al., 1998, p. 26). Proper documentation provides written testimony that patient education has indeed occurred. For at least the past 20 years, the JC has reinforced the federal mandate by requiring documentation of patient and/or family education in the patient record.

Casey (1995) points out that of all lapses in documentation, patient teaching has been identified as "probably the most undocumented skilled service because nurses do not recognize the scope and depth of the teaching they do" (p. 257). Lack of documentation also reflects negligence in adhering to the mandates of the professional practice acts. This laxity is unfortunate because patient records can be subpoenaed for court evidence. Appropriate documentation can be the determining factor in the outcome of litigation. Pure and simple, if the instruction isn't documented, it didn't occur!

Furthermore, documentation is a vehicle of communication that provides critical information to other health professionals involved with the patient's care. Failure to document not only renders other staff potentially liable, but also renders the facility liable and in jeopardy of losing its JC accreditation. Concomitantly, the institution is also in danger of losing its appropriations for Medicare and Medicaid reimbursement. Thus, it behooves the health professional who provides pa-

Table 2–2 LINKAGES BETWEEN ETHICAL PRINCIPLES AND THE LAW

Ethical Principles	Legal Actions/Decisions and Standards of Practice
Autonomy (self-determination)	Cardozo decision regarding informed consent Institutional review boards Patient Self-Determination Act <i>A Patient's Bill of Rights</i> Joint Commission standards Centers for Medicare and Medicaid Services standards
Veracity (truth telling)	Cardozo decision regarding informed consent <i>A Patient's Bill of Rights</i> Health profession practice acts <i>Tuma</i> decision Joint Commission standards Centers for Medicare and Medicaid Services standards
Confidentiality (privileged information)	<i>A Patient's Bill of Rights</i> Health profession practice acts Joint Commission standards Centers for Medicare and Medicaid Services standards Health Insurance Portability and Accountability Act (HIPAA) State public health laws regarding reporting of communicable diseases and duty to warn
Nonmaleficence (do no harm)	Health profession practice acts Malpractice/negligence <i>A Patient's Bill of Rights</i> State health codes Joint Commission standards Centers for Medicare and Medicaid Services standards
Beneficence (do good)	<i>A Patient's Bill of Rights</i> State health codes Job descriptions Professional standards of practice Institutional policies and procedures Joint Commission standards Centers for Medicare and Medicaid Services standards
Justice (equitable distribution of benefits and burdens)	<i>A Patient's Bill of Rights</i> Antidiscrimination/affirmative action laws Americans with Disabilities Act Joint Commission standards Centers for Medicare and Medicaid Services standards

tient education to document it appropriately and be critically conscious of the legal and financial ramifications to the healthcare facility in which he or she is employed.

Snyder (1996) presents an invaluable description of an interdisciplinary method to document patient education. The method involves use of a flow sheet that fits into the client's chart. The flow sheet includes identification of client and family educational needs based on a number of variables; these include the following:

- Readiness to learn (based on admission assessment of the patient)
- Obstacles to learning, which might include language, lack of vision, or other challenges
- Referrals, which might include a patient advocate, the library, or an ethics committee

The form provides documentation space for who was taught (e.g., patient or family), what was taught (e.g., use of resistive exercise bands, proper inhaler technique), when it was taught, what strategies of teaching were used (instructional methods and materials), and how the patient responded to instruction (what outcomes were achieved).

Economic Factors in Healthcare Education: Justice and Duty Revisited

Some might consider the parameters of healthcare economics and finances as objective information that can be used for any number of purposes. Fiscal solvency and forecasting of economic growth of an organization are good examples of such purposes. Others would agree that in addition to the legal considerations that mandate adherence to regulations in health care regardless of the economics involved, there is also an ethical dimension that speaks certainly to quality of care and also to justice, which refers to the equitable distribution of goods and services.

In the interest of patient care, the patient as a human being has a right to good quality care regardless of his or her economic status, national origin, race, and the like. Furthermore, health professionals have a duty to see to it that such services are provided. In like manner, the healthcare organization has the right to expect that it will receive its fair share of reimbursable revenues for services rendered.

Thus, as employees of the provider organization, health professionals have the duty to carry out organizational policies and mandates by acting in an accountable and responsible manner. In an environment of shrinking healthcare dollars, continuous shortages of staff, and dramatically shortened lengths of stay yielding rapid patient turnover, organizations are challenged to ensure the competency of their professional staff to provide educational services, and to do so in the most efficient and cost-effective manner possible. This is an interesting dilemma considering that patient education is identified as a legal responsibility of nurses as well as occupational, physical, and respiratory therapists in their respective state practice acts. Prelicensure education programs are challenged to prepare students adequately for this critical function.

The principle of justice is a critical consideration within the discourse on patient education. The rapid changes and trends so evident in the contemporary healthcare arena are, for the most part, economically driven. Described as chaotic by some, the healthcare system in many ways defies the humanistic and charitable underpinnings that have characterized healthcare services in this country across the decades. Indeed, organizations that provide health care are caught between the proverbial horns of the dilemma of allocating scarce resources in a just yet economically feasible manner.

On the one hand, the realities of capitation and managed care result in shrinking revenues. This trend, in turn, dictates shorter patient stays

in hospitals and doing more with less. Despite continued, severe shortages of healthcare personnel in most geographic areas of the country, healthcare facilities are concomitantly expanding their clinical expertise into satellite types of ambulatory and home care services. On the other hand, these same organizations are held to the exact standards of care that are underwritten by *A Patient's Bill of Rights* (AHA, 1992), which is regulated as a contingency of Medicare and Medicaid participation by the CMS and for agency accreditation by the JC. In turn, although there are some exceptions (e.g., home healthcare agencies), hospital accreditation in particular dictates eligibility for third-party reimbursement in both the public and private sectors. Thus, the regulated right of clients to health education carries a corresponding duty of healthcare organizations to provide that service.

Financial Terminology

Given the fact that the role of certain health professionals as educators is an essential aspect of care delivery, included is an overview of fiscal terminology that directly affects both staff and patient education. Such educational services are not provided without an accompanying cost of human and material resources. Thus, it is important to know that expenditures are essentially classified into two categories: direct and indirect costs.

Direct Costs

Direct costs are tangible, predictable expenditures, a substantial portion of which include personnel salaries, employment benefits, and equipment (Gift, 1994). This portion of an organizational budget is almost always the largest of the total budgetary outlay of any healthcare facility.

Because of the labor-intensive function of healthcare delivery, the costs of salaries and benefits usually account for at least 50%—if not more—of the total facility budget. Of course, the higher the

educational level of professional staff, the higher the salaries and benefits, and thus, the higher the institution's total direct costs.

Although the purpose of salary is to buy an employee's time and particular expertise, it is often difficult to predict how long it will take to plan, implement, and evaluate various educational programs being offered. For example, if planning and carrying out patient or staff education exceed the allocated time and the healthcare educator draws overtime pay, the extra cost may not have been anticipated in the budget planning process.

Time is also considered a direct cost and is a major factor included in a cost-benefit analysis. In other words, if the time it takes to prepare and offer patient or staff education programs is greater than the financial gain to the institution, the facility may seek other ways of providing this service, such as computerized programmed instruction or a patient television channel.

Also, equipment is classified as a direct cost. No organization can function without proper equipment and the need to replace it when necessary. Teaching requires written materials, audiovisual tools, and equipment for the delivery of instruction, such as handouts and brochures, models, closed-circuit televisions, computers, and copy machines. Although renting or leasing equipment may sometimes be less expensive than purchasing it, rental and leasing costs are still categorized as direct costs.

Direct costs are divided into two types: fixed and variable. **Fixed costs** are those that are predictable, remain the same over time, and can be controlled. Salaries, for example, are fixed costs because they remain relatively stable and can also be manipulated. The facility usually makes annual decisions to give employee raises, to freeze salaries, or to cut positions, thereby influencing the budgeted amount for direct cost expenditures. In addition, mortgages, loan repayments, and the like are included as fixed costs.

Variable costs are those costs that, in the case of healthcare organizations, depend on volume. The

number of meals prepared, for example, depends on the patient census. From an educational perspective, the demand for patient teaching depends on the number and diagnostic types of patients. For example, if the volume of total hip replacement patients is low, educational costs may be high resulting from the fact that intensive one-to-one instruction must be offered to each patient admitted. Conversely, if the volume of total hip replacement surgeries is high, it is less expensive to provide standardized programs of instruction via group teaching sessions. As another example, if demand or turnover of health professions staff increases, the number of orientation sessions for new employees would also increase in volume. Supplies, also a direct, variable cost, can change depending on the amount and type needed. Variable costs can become fixed costs when volume remains consistently high or low over time.

Indirect Costs

Indirect costs are those costs not directly related to the actual delivery of an educational program. These include, but are not limited to, institutional overhead such as heating and air conditioning, lighting, space, and support services of maintenance, housekeeping, and security. Such services are necessary and ongoing whether or not an educational session is in progress.

Hidden costs, a type of indirect cost, can neither be anticipated nor accounted for until after the fact. Low employee productivity can produce hidden costs. Organizational budgets are prepared on the basis of what is known and predictable, with projections for variability in patient census included. Personnel budgets are based on levels of staff needed (e.g., number of radiographers, CT technicians, MRI technicians, and ultrasonographers) to accommodate the expected patient volume. This is determined by an annual projection of patient days and how many patients an employee can effectively care for on a daily basis. Low

productivity of one or two health professionals in a department or unit, for example, can have a significant impact on the workload of others, which, in turn, leads to low morale and employee turnover. Turnover increases recruitment and new employee orientation costs. In this respect, the costs are appropriately identified as hidden.

In a classic description of understanding costs, Gift (1994) makes a point of distinguishing between costs—direct or indirect—and charges. As just described, direct and indirect costs are those expenses incurred by the facility. Charges are set by the provider, but they are billed to the recipient of the services. There may or may not be equivalence between costs and charges. In the retail business, for example, if costs of raw materials are low, while charges for the items, goods, or services are high, the retailer yields a profit. In the healthcare arena, not-for-profit organizations are limited by federal law as to the amount they can charge in relation to the actual cost of a service. In many instances, particularly as it relates to pharmaceutical goods, the actual cost to the facility is what is charged. As such, the facility provides a service but realizes no financial profit (Kaiser Family Foundation, 2005).

Cost Savings, Cost Benefit, and Cost Recovery

Patient teaching is mandated by state laws, professional and institutional standards, accrediting body protocols, and regulations for participation in Medicare and Medicaid reimbursement programs. However, unless it is ordered by a physician, patient education costs are generally not recoverable as a separate entity under third-party reimbursement. Even though the costs of educational programs, for both patients and professional staff, are a legitimate expense to the facility, these costs usually are subsumed under hospital room rates and are, therefore, technically absorbed by the healthcare organization.

Hospitals realize **cost savings** when patient lengths of stay are shortened or fall within the allotted diagnostic related group (DRG) time frames. Patients who have fewer complications and use less expensive services will yield a cost savings for the institution. In an ambulatory care setting, cost savings may be realized when patient education keeps people healthy and independent for a longer period of time, thereby preventing high utilization of expensive diagnostic testing or inpatient services. However, and perhaps most important, patient education becomes even more essential when a pattern of early discharge is detected, resulting in frequent readmissions to a facility. The facility comes under scrutiny by HCFA/CMS and may be penalized either through citation or loss of payment—in which case any cost savings may be more than offset by the penalties incurred.

Cost benefit occurs when there is increased patient satisfaction with an institution as a result of the services it renders, including educational programs it provides such as childbirth classes, weight and stress reduction sessions, and cardiac fitness and rehabilitation programs. This is an opportunity for an institution to capture a patient population for lifetime coverage. Patient satisfaction is critical to individuals' return for future healthcare services.

Cost recovery results when either the patient or insurer pays a fee for educational services that are provided. Cost recovery can be realized through the marketing of health education programs offered for a fee. Also, under Medicare and Medicaid guidelines, reimbursement may be made for programs “furnished by providers of services to the extent that the programs are appropriate, integral parts in the rendition of covered services which are reasonable and necessary for the treatment of the individual’s illness or injury” (Kaiser Family Foundation, 2005). The key to success in obtaining third-party reimbursement is the ability to demonstrate that as a result of education,

patients can manage self-care at home and consequently experience fewer hospitalizations.

To take advantage of cost recovery, hospitals and other healthcare agencies develop and market a cadre of health education programs that are open to all members of a community. If well attended, fee-for-service programs can result in revenues for the institution. The critical element, of course, is not only the recovery of costs but also revenue generation. **Revenue generation** (i.e., profit) refers to income realized over and above program costs.

To offset the dilemma of striving for cost containment and solvency in an environment of shrinking fiscal resources, healthcare organizations have developed alternative strategies for patient education to realize cost savings, cost benefit, cost recovery, or revenue generation. For example, a preoperative teaching program for surgical patients given prior to admission to the hospital has been found to lower patient anxiety, increase patient satisfaction, and decrease nursing hours during hospitalization (Wasson & Anderson, 1993).

Program Planning and Implementation

The key elements to consider when planning a patient education offering intended for generation of revenue include an accurate assessment of direct costs such as paper supplies, printing of program brochures, publicity, rental space, and time (based on an hourly rate) required of professional personnel to prepare and offer the service. If an hourly rate is unknown, a simple rule of thumb is to divide the annual base salary by 2,080, which is the standard number of hours for which people working full-time are paid in the course of one year.

If the program is to be offered on the premises of the facility, there may be no need to plan for a rental fee for space. However, indirect costs such as housekeeping and security should be prorated as a

bona fide expense. Such a practice not only is good fiscal management, but also provides an accounting of the contributions of other departments to the educational efforts of the facility.

Fees for a program should be set at a level high enough to cover the aggregate costs of program preparation and delivery. If the intent of an education program is for cost savings to the facility, such as provision of education classes for diabetics in the community to reduce the number of costly hospital admissions, then the aim may be to break even on costs. The price is set by dividing the calculated cost by the number of anticipated attendees. If the goal is for cost benefit to the institution, success can be measured by increased patient satisfaction (as determined by questionnaires or evaluation forms) or by an increase in the use of the sponsor's services (as determined by record keeping). If the intent is to offer a series of classes for smoking cessation or childbirth to improve the wellness of the community and to generate income for the facility, then the fee is set higher than cost so as to realize a profit (cost recovery).

It is usually necessary for the health professionals providing the program to give an annual report to administration of time and money spent and whether such expenditures were profitable to the institution in terms of cost savings, cost benefit, or cost recovery.

Cost-Benefit Analysis and Cost-Effectiveness Analysis

In the majority of healthcare organizations, the education department bears the major responsibility for staff development, for in-service employee training, and for patient education programs that exceed the boundaries of bedside instruction. Total budget preparation for these departments is best explained by the experts in the field. Fisher, Hume, and Emerick (1998), for example, address the need

for staff development departments to engage in responsibility-centered budgeting, which also is referred to as activity-based management. Given the shift away from providing at-will services and toward greater demand for cost accountability for educational programs, they propose a template for costing out programs that allows staff development departments to identify and recoup their true costs while responding to increased market competition.

There is no single best method for measuring the effectiveness of patient education programs. Most experts in the field tend to rely on determining actual costs or actual impact of programs in relationship to outcomes by employing one of two concepts: cost-benefit analysis or cost-effectiveness analysis (Abruzzese, 1992).

Cost-benefit analysis measures the relationship between costs and outcomes. Outcomes can be the actual amount of revenue generated as a result of an educational offering, or they can be expressed in terms of shorter patient stays or reduced hospitalizations for particular diagnostic groups of patients. If, under DRGs or capitation methods of reimbursement, the facility makes a profit, this can be expressed in monetary terms. If an analysis reveals that an educational program costs less than the revenue it generates, that expense can be recovered by third-party reimbursement. If savings exceed costs, then the program is considered to be a cost benefit for the facility. The measurement of costs against monetary gains is commonly referred to as the **cost-benefit ratio**.

Cost-effectiveness analysis measures the impact an educational offering has on patient behavior. If program objectives are achieved, as evidenced by positive and sustained changes in behavior of the participants over time, the program is said to be cost effective. Although behavioral changes are highly desirable, in many instances they are less observable, less tangible, and not easily measurable. For example, reduction in patient anxiety cannot

be converted into a gain in real dollars. Therefore, it is wise to analyze the outcome of teaching interventions by comparing behavioral outcomes between two or more programs to identify the one that is most effective and efficient when actual costs cannot be determined.

A health professional as educator may be called upon to interpret the costs of behavioral changes (outcomes) to the institution by conducting a cost-effectiveness analysis between programs. This can be accomplished by first identifying and itemizing for each program all direct and indirect costs, including any identifiable hidden costs. Second, it is necessary to identify and itemize any benefits derived from the program offering, such as revenue gained or decreased readmission rates that can be expressed in monetary values. Results of these findings can then be recorded on a grid so that each program's cost effectiveness is visually apparent (see **Figure 2–1**).

Figure 2–1 Cost-Effectiveness Grid

Program	I	II
Costs		
Direct	\$	\$
Indirect	\$	\$
Hidden	\$	\$
Benefits		
Decreased readmissions	\$	\$
Revenue generated	\$	\$
Total	\$	\$

Mitton and Donaldson (2004) suggest a non-vested team approach to an analysis of program effectiveness for the purpose of determining the allocation or reallocation of valuable resources between and among services or programs. This approach ensures the integrity of the total process of program evaluation. In addition to this recommendation, the International Council of Nurses published a position statement in 2001 that, among other things, obligates nurses to demonstrate their value in promoting cost-effective, quality care by playing a leadership role in program planning and evaluation, in policy setting, and in interactive networking on cost-effectiveness research, cost-saving strategies, and best practice standards (Ghebrehiwet, 2005).

State of the Evidence

Practice driven by evidence is defined as practice “based on research, clinical expertise, and patient preferences that guide decisions about the health care of individual patients” (HPNA Position Paper, 2004, p. 66). Much evidence suggests that ethical principles and theories play a highly significant role in shaping contemporary healthcare delivery practices and decision making. Whereas complex and technological advances in health care have given rise to numerous questions about what is right or wrong—or more or less morally defensible—few situations yield clear-cut or perfectly right answers to solving a problem or need. Numerous case studies, books, and articles on how to deal with ethical dilemmas in health care abound. They attempt to provide evidence for how to deliver health care, including patient education, in the most equitable and beneficial manner possible. Our increasingly multicultural and pluralistic society is challenged to address the vast array of biomedical ethical issues confronting healthcare practitioners on a daily basis in a

way that preserves an individual's rights but also protects the well-being of other persons, groups, and communities. Health professionals who deal directly with clients have many more resources to turn to than do those whose involvement with client care is more removed.

Laws and standards governing the role of certain health professionals as patient educators are firmly established and provide the legal foundations and professional expectations for the delivery of high-quality client care. Also well established is the importance of documenting client education interventions. More research must be conducted to provide evidence of the frequency and amount of informal patient education health professionals provide that never gets recorded in the chart. In addition, although strategies exist for analyzing the cost effectiveness and cost benefit of educational programming offered by health professionals, more research evidence is needed to substantiate the value of the educator's role in influencing overall costs of care.

Further comparative analysis research needs to be conducted to determine what types of patient education programs are the most equitable, beneficial, and cost effective for clients, professional staff, the institution, and the communities served. Evidence is scarce on the economics associated with various approaches to education and the value of the health professional's role as it affects behavioral

outcomes related to cost savings, cost benefit, and cost recovery.

Summary

Ethical and legal dimensions of human rights provide the justification for client education, particularly as it relates to issues of self-determination and informed consent. These rights are enforced through federal and state regulations and through performance standards promulgated by accrediting bodies and professional organizations for implementation at the local level. The health professional's role as educator is legitimized through the definition of each discipline's practice as set forth by the prevailing laws and codes of ethics governing professional conduct in various employment settings. In this respect, client education is a duty that is grounded in justice; that is, the direct care providers have a responsibility to provide patient education and all clients, regardless of their age, gender, culture, race, ethnicity, literacy level, religious affiliation, or other defining attributes have a right to health education relevant to their physical and psychosocial needs. Justice also dictates that education programs should be designed to be consistent with organizational goals while meeting the needs of clients to be informed, self-directed, and in control of their own health, and ultimately of their own destiny.

REVIEW QUESTIONS

1. What are the definitions of the terms *ethical*, *moral*, and *legal*, and how are they distinct from one another?
2. Which national, state, professional, and private-sector organizations legislate, regulate, and provide standards to ensure the protection of human rights in matters of health care?
3. Which ethical viewpoint, deontological or teleological, refers to the decision-making approach that choices should be made for the common good of people?

4. With respect to ethical, moral, and legal obligations, how does the American Hospital Association's *A Patient's Bill of Rights* compare with the codes of ethics of the various health professions?
5. What are six ethical principles that dictate the actions of health professionals in delivering services to clients?
6. Why are practice acts useful to health professionals in carrying out their roles and responsibilities to educate the public they serve?
7. What is the difference between *negligence* and *malpractice*?
8. When was informed consent established as a basic tenet of ethics and which health professionals are accountable in situations involving informed consent?
9. How can ethical principles be applied specifically to the teaching of clients? Give an example for each of the principles described in this chapter.
10. How does ethics fit into the relationships between student and teacher and client and health professional in the classroom and practice setting, respectively?
11. Why is documentation of patient education efforts so important in the provision of care by health professionals?
12. What are four examples of direct costs and five examples of indirect costs in the provision of patient/staff education?
13. What are the definitions of the following terms: *fixed direct costs*, *variable direct costs*, *indirect costs*, *cost savings*, *cost benefit*, *cost recovery*, *cost-benefit analysis*, and *cost-effectiveness analysis*?

CASE STUDY*

Laura, a cytotechnology student, is practicing for an exam by reading slides from a study set from 5 years ago. On one slide of a cervical specimen, Laura believes she sees malignant cells. However, the slide had originally been read as normal by the cytotechnologist who, coincidentally, is now her instructor. She shows the slide to her instructor, who agrees with Laura—the cervical cells indeed show malignancy, and the specimen is not normal as originally read. Laura's instructor commends her on this “good pick-up.” When Laura asks if they should inform anyone about the error, her instructor says no. He reasons that if they were to point out his past mistake, others might lose their confidence in him and, besides, there would probably be no clinical impact because the specimen was already 5 years old.

1. What are plausible actions that Laura could take at this point?
2. What are the ethical reasons Laura would rely on to justify the plausible actions in question 1?
3. Which of her actions and associated justifications seem the most morally defensible to you? Why?

* This case is adapted from an actual student case.

References

- Abruzzese, R. S. (1992). *Nursing staff development: Strategies for success*. St. Louis, MO: Mosby.
- American Hospital Association. (1975). *Patient's bill of rights*. Chicago: Author.
- American Hospital Association. (1992). *A patient's bill of rights*. Retrieved March 27, 2007, from http://www.patienttalk.info/AHA-Patient_Bill_of_Rights.htm
- American Medical Association. (2001). *The principles of medical ethics*. Retrieved March 2, 2010, from <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics.shtml>
- American Nurses Association. (1976). *Code of ethics for nurses with interpretive statements*. Kansas City, MO: Author.
- American Nurses Association. (1985). *Code of ethics for nurses with interpretive statements*. Kansas City, MO: Author.
- American Nurses Association. (2001). *Code of ethics for nurses with interpretive statements*. Washington, DC: American Nurses Publishing. Retrieved January 20, 2007, from <http://www.nursingworld.org/MainMenu/Categories/EthicsStandards/CodeofEthicsforNurses.aspx>
- Association of American Physicians and Surgeons. (1995). *Patients' bill of rights*. Retrieved March 27, 2007, from <http://www.aapsonline.org/patients/billrts.htm>
- Beauchamp, T., & Childress, J. (1977). *Principles of biomedical ethics*. New York: Oxford University Press.
- Bekker, H. L. (2010). The loss of reason in patient decision aid research: Do checklists damage the quality of informed choice interventions? *Patient Education and Counseling*, doi:10.1016/j.pec.2010.01.002.
- Boyd, M. D., Gleit, C. J., Graham, B. A., & Whitman, N. I. (1998). *Health teaching in nursing practice: A professional model* (3rd ed.). Stamford, CT: Appleton & Lange.
- Brent, N. J. (2001). *Nurses and the law* (2nd ed.). Philadelphia: Saunders.
- Buckwalter, J. G. (2007). The good patient. *New England Journal of Medicine*, 357(25), 2534–2535.
- Casey, F. S. (1995). Documenting patient education: A literature review. *Journal of Continuing Education in Nursing*, 26(6), 257–260.
- Centers for Disease Control and Prevention. (2005). Tuskegee timeline. Retrieved March 27, 2007, from <http://www.cdc.gov/nchstp/od/tuskegee/time.htm>
- Christakis, D. A., & Feudtner, C. (1997). Temporary matters: The ethical consequences of transient social relationships in medical training. *Journal of the American Medical Association*, 278(9), 739–743.
- Cisar, N. S., & Bell, S. K. (1995). Informed consent: An ethical dilemma. *Nursing Forum*, 30(3), 20–28.
- Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, 42 U.S.C. 135dd§1867.
- Creighton, H. (1986). Informed consent. *Nursing Management*, 17(10), 11–13.
- deBocanegra, H. T., & Gany, F. (2004). Good provider, good patient: Changing behaviors to eliminate disparities in healthcare. *American Journal of Managed Care*, 10, SP20–SP28.
- Dickey, S. B. (2006). Informed consent: Ethical issues. In V. D. Lachman (Ed.), *Applied ethics in nursing*. New York: Springer.
- Donetto, S. (2010). Medical students' views of power in doctor–patient interactions: The value of teacher–learner relationships. *Medical Education*, 44, 187–196.
- Edward, P. (1967). Kant, Immanuel. In *Encyclopedia of philosophy*. New York: Macmillan.
- Emanuel, E. J. (2000). Justice and managed care: Four principles for the just allocation of health care resources. *Hastings Center Report*, 30(3), 8–16.
- Ewashen, C., & Lane, A. (2007). Pedagogy, power and practice ethics: Clinical teaching in psychiatric/mental health settings. *Nursing Inquiry*, 14(3), 255–262.
- Federation of State Boards of Physical Therapy. (2006). *The model practice act for physical therapy* (4th ed.). Retrieved March 8, 2010, from <https://www.fsbpt.org/RegulatoryTools/ModelPracticeAct/index.asp>
- Fisher, M. L., Hume, R., & Emerick, R. (1998). Costing nursing education programs: It's as easy as 1-2-3. *Journal for Nurses in Staff Development*, 14(5), 227–285.
- Flook, D. M. (2003). The professional nurse and regulation. *Journal of PeriAnesthesia Nursing*, 18(3), 160–167.
- Freedman, T. G. (2003). Prescriptions for health providers: From cancer patients. *Cancer Nursing*, 26(4), 323–330.
- Ghebrehiwet, T. (2005). The ICN code of ethics for nurses. Helping nurses make ethical decisions. *Reflections on Nursing Leadership*, 31(3), 26–28. Retrieved January 18, 2007, from http://www.nursingsociety.org/RNL/3Q_2005/features/features6.html
- Gift, A. G. (1994). Understanding costs. *Clinical Nurse Specialist*, 8(2), 90.
- Hall, J. K. (1996). *Nursing ethics and the law*. Philadelphia: Saunders.

- Hall, K. (1992). Cardozo, Benjamin N. In *The Oxford Companion to the Supreme Court of the United States* (pp. 126–127). New York: Oxford University Press.
- HPNA position paper. (2004). Value of the professional nurse in end-of-life care. *Journal of Hospice and Palliative Nursing*, 6(1), 65–66.
- International Council of Nursing. (2001). Position statement. Promoting the value and cost-effectiveness of nursing. Retrieved February 15, 2007, from <http://www.icn.ch/psvalue.htm>
- Kaiser Family Foundation. (2005). Navigating Medicare and Medicaid, 2005. Retrieved March 27, 2007, from <http://kff.org/medicare/7240.cfm>
- Kohlenberg, E. M. (2006). Patients' rights and ethical issues. In V. D. Lachman (Ed.), *Applied ethics in nursing* (pp. 39–46). New York: Springer.
- Legal Action Center. (2001). *HIV/AIDS. Testing, confidentiality, and discrimination*. New York: Legal Action Center of the City of New York.
- Lesnick, M. J., & Anderson, B. E. (1962). *Nursing practice and the law*. Philadelphia: Lippincott.
- Martinez, R. (2000). A model for boundary dilemmas: Ethical decision-making in the patient–professional relationship. *Ethical Human Sciences and Services*, 2(1), 43–61.
- Mezey, M., Evans, L. K., Golob, Z. D., Murphy, E., & White, G. B. (1994). The patient self-determination act: Sources of concern for nurses. *Nursing Outlook*, 42(1), 30–38.
- Mikos, C. A. (2004). Inside the nurse practice act. *Nursing Management*, 35(9), 20, 22, 91.
- Mitton, C., & Donaldson, C. (2004). Health care priority setting: Principles, practice and challenges. *Cost Effectiveness and Resource Allocation*, 2(3). Retrieved February 20, 2007, from <http://www.resource-allocation.com/content/2/1/3>
- New York State Nurses Association. (1972). New York state nurse practice act. Retrieved March 4, 2007, from <http://www.op.nysed.gov/nurse.htm>
- New York State Nurses Association. (2001). Code of ethics for nurses with interpretative statements. *NYSNA Report*, 32(7), 5–7.
- Pellegrino, E. (1993). The metamorphosis of medical ethics: A thirty-year retrospective. *Journal of the American Medical Association*, 269, 1158–1162.
- President's Advisory Commission on Consumer Protection and Quality in the Healthcare Industry. (1998). Consumer bill of rights and responsibilities. Retrieved January 20, 2007, from http://www.hcqualitycommission.gov/final/append_a.html
- Rankin, S. H., & Stallings, K. D. (1990). *Patient education: Principles and practices*. Philadelphia: Lippincott.
- Redman, B. K. (2008). When is patient education unethical? *Nursing Ethics*, 15(6), 813–820.
- Reiser, S. J. (1993). Science, pedagogy, and the transformation of empathy in medicine. In H. Spiro, M. G. McCrea Curnen, E. Peschel, & D. St. James (Eds.), *Empathy and the practice of medicine*. New Haven, CT: Yale University Press.
- Reiser, S. J. (1994). The ethics of learning and teaching in medicine. *Academic Medicine*, 69(11), 872–876.
- Reising, D. L., & Allen, P. N. (2007). Protecting yourself from malpractice claims. *American Nurse Today*, 2(2), 39–44.
- Rivera, G. (1972). *Willowbrook: A report on how it is and why it doesn't have to be that way*. New York: Vintage Books.
- Schloendorff v. Society of New York Hospitals, 211 NY 125, 128, 105 N.E. 92, 93 (1914).
- Snyder, B. (1996, March). An easy way to document patient ed. *RN*, 43–45.
- Thomas, S. B., & Quinn, S. C. (1991). The Tuskegee Syphilis Study, 1932 to 1972: Implications for HIV education and AIDS risk education programs in the black community. *American Journal of Public Health*, 81(11), 1498–1505. Retrieved March 27, 2007, from <http://ajph.aphapublications.org/cgi/content/abstract/81/11/1498>
- Tong, R. (2007). *New perspectives in health care ethics*. Upper Saddle River, NJ: Pearson Prentice Hall.
- Ulrich, L. P. (1999). *The Patient Self-Determination Act: Meeting the challenges in patient care*. Washington, DC: Georgetown University Press.
- U.S. Department of Health and Human Services. (1983). Protection of human subjects: Reports of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. *Federal Register*, 48(146), 34408–34412.
- Visser, A. (1998). Ethical issues in patient education and counseling. *Patient Education and Counseling*, 35, 1–3.
- Wasson, D., & Anderson, M. (1993). Hospital-patient education: Current status and future trends. *Journal of Nursing Staff Development*, 10(3), 147–151.
- Weisbard, A. J., & Arras, J. D. (1984). Commissioning morality: An introduction to the symposium. *Cardozo Law Review*, 6(4), 223–241.
- Wittmann-Price, R. A., & Fisher, K. M. (2009). Patient decision aids: Tools for patients and professionals. *American Journal of Nursing*, 109(12), 60–63.
- Yoder-Wise, P. S. (1995). *Leading and managing in nursing*. St. Louis, MO: Mosby.
- Zucker, E. J. (2009). The good patient. *Academic Medicine*, 84(4), 524.