

# Legal, Ethical, and Safety Issues in the Healthcare Workplace

## Learning Objectives

The student will be able to:

- Describe the legal relationship between patient and provider.
- Apply civil and criminal liability concepts to healthcare providers and consumers.
- Analyze six employment laws and their importance to the healthcare workplace.
- Examine the concept of ethics and its application to healthcare organizations.
- Discuss a healthcare ethical dilemma.

## DID YOU KNOW THAT?

- The healthcare industry is one of the most regulated industries in the United States.
- The National Defense Authorization Act of 2008 allows an employee to take 12 weeks of unpaid leave if a child, spouse, or parent has been called to active duty.
- Voluntary hospitals are no longer exempt from lawsuits.
- According to civil law, surgery performed by a surgeon without consent could be considered assault and battery.
- Providers may order more tests and provide more services to protect themselves from medical malpractice lawsuits.

## ■ Introduction

To be an effective manager, it is important to understand basic legal and ethical principles that influence the work environment, including the legal relationship between the organization and the consumer—the healthcare provider and the patient. Ethical behavior, which is considered actions that are the right thing to do, not simply what is required by law, must also be described because the healthcare industry is fraught with difficult situations that involve ethical dilemmas. It is the responsibility of the human

resources (HR) department to make employees knowledgeable in the information presented in this chapter. The basic concepts of law, both civil and criminal healthcare law, tort reform, employment-related legislation, safety in the workplace, workplace ethics, and the provider–patient relationship, healthcare organizational codes of ethics, public health ethics, research ethics, and workplace bullying will be described in this chapter.

## ■ Basic Concepts of Law in the Healthcare Workplace

The healthcare industry is one of the most heavily regulated industries in the United States. Those who provide, receive, pay for, and regulate healthcare services are affected by the law (Miller, 2006a). **Law** is a body of rules for the conduct of individuals and organizations. Law is created so that there is a minimal standard of action required by individuals and organizations. There exist laws created by federal, state, and local governments. When the judiciary system interprets previous legal decisions with respect to a case, they create **common law** (Buchbinder & Shanks, 2007). The minimal standard for action is federal law, although state law may be more stringent. Legislatures create laws that are called **statutes**. Both common law and statutes are then interpreted by administrative agencies by developing **rules and regulations** that interpret the law.

There exist civil and criminal laws that affect the healthcare industry. **Civil law** focuses on the wrongful acts against individuals and organizations based on contractual violations. In civil law, **torts**, derived from the French word for *wrong*, is a category of wrongful acts or negligence that can result in different types of healthcare violations. To prove a civil infraction, you do not need as much evidence as in a criminal case. **Criminal law** is concerned with actions that are illegal based on court decisions. To convict someone of a criminal activity, it has to be proved without a reasonable doubt of guilt. Examples of criminal law infractions would be Medicare and Medicaid fraud (Miller, 2006b).

As stated earlier, torts are wrongdoings that occur to individuals or organizations regardless of whether a contract is in place. Medical malpractice cases are examples of torts. There are several different types of violations that can apply to health care. There are two basic healthcare torts: (1) **negligence**, which involves the unintentional act or omission of an act that could negatively contribute to the health of a patient, and (2) **intentional torts**, such as assault and battery and invasion of privacy (Buchbinder & Shanks, 2007).

An example of negligence is if a provider does not give appropriate care or withholds care that results in damages to the patient's health. In the healthcare industry, intentional torts such as **assault** and **battery** would be a surgeon performing surgery on a patient without his or her consent (Miller, 2006c). An example of **invasion of privacy** would be the violation of patients' health records. Privacy relating to patient information is a major issue in the healthcare industry. As more information that is

confidential is shared electronically, there is an increased risk of invasion of privacy. These examples are categorized under the term *medical malpractice*.

According to the *American Heritage Dictionary*, **medical malpractice** is the “Improper or negligent treatment of a patient by a provider which results in injury, damage or loss” (*American Heritage Dictionary*, 2000). According to the Institute of Medicine’s landmark report *To Err Is Human*, medical malpractice results in approximately 80,000 to 100,000 deaths per year. The Congressional Budget Office (CBO) found that in 2003 there were over 180,000 severe injuries due to medical negligence. Harvard School of Medicine researchers indicate that in 2005 nearly 20% of hospital patients are injured during their care (Medical Negligence, 2011). Disputes over improper care of a patient have hurt both providers and patients. Patients have sued physicians because of the belief that the physician has not given the patient a level of care comparable with the **standard of care** established in the industry.

## ■ Tort Reform Discussion

As a result of the number of malpractice claims in the United States, malpractice insurance premiums have increased, which has resulted in the introduction of **defensive medicine**, which means that providers order more tests and provide more services than necessary to protect themselves from malpractice lawsuits (Shi & Singh, 2008a). In addition, some states are no longer offering malpractice insurance, which means there are fewer physicians in needed areas resulting in geographic maldistribution of physicians. Malpractice insurance crises occurred during the 1970s and 1980s (Danzon, 1995). The issues in the 1970s led to joint underwriting measures that required insurance companies to offer medical malpractice if the physician purchased other insurance. In some states, compensation funds were established to offset large award settlements. The number of malpractice suits decreased, but the amounts of awards were still huge. During the mid-1980s, the premiums rose again—nearly 75% (Rosenbach & Stone, 1990). A third malpractice insurance crisis occurred in the first decade of the 21st century. Issues with obtaining medical malpractice insurance in several states have increased, forcing physicians to turn to joint underwriting associations, which can charge exorbitant premiums.

As a result of the recent malpractice insurance crisis, more states have adopted statutory caps on monetary damages that a plaintiff can recover in malpractice claims. States believe that a **monetary cap** on malpractice claims would limit the increase of malpractice insurance premiums. The less an insurance company has paid out in malpractice insurance claims, the less the insurance company would have to raise insurance rates. According to the National Conference of State Legislatures, in 2005 there were 48 states that considered malpractice reform legislation with 30 states adopting law (Waters, Budetti, Claxton & Lundy, 2007). For example, Nevada adopted a cap of \$350,000 on noneconomic damages in medical malpractice cases. However, some

state appellate courts have declared caps to be unconstitutional (Nelson, Morrisey & Kilgore, 2007). Studies have been contradictory regarding the positive impact that monetary caps have on reducing malpractice insurance rates. States have also developed several other **tort reform** measures that relate to filing claims such as limiting attorney's fees, setting a statute of limitations on claims, and adhering to alternative dispute resolution methods, which are typically less costly than court disputes.

Many legal factors have also contributed to the increase in claims. **Voluntary hospitals**, which are private and not for profit, are no longer exempt from malpractice suits. Employers now have to take responsibility for their employees' wrongdoing. The concept of **informed consent** parameters, which means the patient is provided accurate information prior to any medical treatment, has expanded and therefore increased claims have occurred. The acceptable **standard of care**, which used to be strictly based on a similar community's medical care standard, has now become a state or national standard, which has also resulted in increased claims (Miller, 2006c).

Expert witness qualifications are also specified to ensure that the witness is an expert in his or her field. Clinical practice guidelines, which are developed to ensure an acceptable standard of care, are also used (Miller, 2006d). The informed consent of a patient to receive care was also expanded in the 1970s to become a patient-friendly standard that specifies what information must be given to the patient to ensure he or she is making an informed decision regarding his or her care (Office of Technology Assessment, 1993).

Some physicians are leaving private practice because they can no longer afford the premiums—they are now in administrative positions at all levels of government, are academicians, or teach at medical universities. The malpractice insurance issues have forced many states to review their malpractice guidelines. In some states, tort reform that has imposed limits on the amount awarded continues to cause controversy. However, recent federal studies have indicated that imposing caps on awards may be an effective method to reduce malpractice costs and to discourage frivolous lawsuits. In addition, the U.S. Supreme Court ruled that any awards must be included in an individual's taxed income (Miller, 2006e).

It is the responsibility of the HR department to ensure that healthcare employees are aware of these litigious issues and are trained to deal with patients in accordance with these legal issues. HR management must also train employees with respect to the impact of employment-related healthcare legislation. The following section outlines major human resources-related legislation that influences the healthcare industry (Table 2.1).

## ■ Human Resource-Related Legislation

### Equal Pay Act of 1963 (Amended FLSA)

This act, which amended the Fair Labor Standards Act and is enforced by the U.S. Department of Labor, mandates that all employers award pay fairly to both genders

**Table 2.1** Major Human Resource-Related Legislation

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**Equal Pay Act of 1963:** All employers must provide equal pay to both genders that have the same position with equal responsibilities and skills. Enforced by the U.S. Department of Labor.

**Civil Rights Act of 1964, Title VII:** Landmark legislation. Prohibits discrimination of protected classes based on gender, race, color, religion, and national origin. Enforced by the EEOC. Applies to employers with 15 or more employees.

**Age Discrimination in Employment Act of 1967 (ADEA):** Protects employees and job applicants 40 years or older from discrimination in hiring, firing, promotion, layoffs, training, benefits, and assignments. Enforced by EEOC. Applies to employers with 20 or more employees.

**Occupational Safety and Health Act of 1970:** This act requires employers to provide a safe and healthy work environment. Guidelines for working with hazardous chemicals and for working ergonomically. Enforced by the Occupational Safety and Health Administration.

**Rehabilitation Act of 1973:** Employers with 50 or more employees and with federal funding of \$50,000 must submit an affirmative action plan. Amended to ensure that healthcare facilities are accessible for the disabled. Enforced by the Office of Federal Contract Compliance Programs.

**Employee Retirement Income Security Act of 1974 (ERISA):** Regulates pensions and benefit plans for employees. Forbids employers from firing employees so the employers do not have to pay the employee's medical coverage. Gives employees the right to sue for breaches of any fiduciary duty. Enforced by the U.S. Department of Labor.

**Pregnancy Discrimination Act of 1978:** Protects female employees who are pregnant against discrimination. Applied to employers with 15 or more employees. Enforced by the EEOC.

**Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA):** Passed to ensure that if an individual changes jobs, he or she can still obtain health insurance. Enforced by the U.S. Department of Labor.

**Worker Adjustment and Retraining Notification Act of 1989:** Employers with 100 employees or more must give their employees 60 days notice of layoffs and closings. U.S. Department of Labor has no enforcement role but can assist with job placement.

**Americans with Disabilities Act of 1990 (ADA):** Protects the disabled from employment discrimination. Encourages businesses to provide reasonable accommodation in the workplace for qualified individuals that have disabilities but are able to perform a job. Applies to employers with 15 or more employees. Enforced by the EEOC. Its 2008 amendments expanded the concept of disabilities.

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**Table 2.1** (Continued)

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**Older Workers Benefit Protection Act of 1990 (OWBPA):** Amended the ADEA. Benefits must be provided to both younger and older workers. Gives time to accept early retirement options and allows employees to change their mind if they want to litigate against their company. Enforced by the EEOC.

**Civil Rights Act of 1991:** Amendment to 1964 Act. Enables individuals to receive monetary damages up to \$300,000 because of intentional discrimination. Enforced by the EEOC. Applies to employers with 15 or more employees. This Act also established the Glass Ceiling Commission that examined the lack of protected classes in senior management positions.

**Family Medical Leave Act of 1993 (FMLA):** Requires employers with 50 or more employees within a 75-mile radius who work more than 25 hours per week and who have been employed more than 1 year to provide up to 12 work weeks of unpaid leave to an employee during any 12-month period so the employee may provide care for a family member or obtain care for himself or herself. Enforced by the U.S. Department of Labor.

**Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA):** Workers are entitled to return to their job after military service. Returning employees are not penalized from raises or promotions because they were in the military. The U.S. Department of Labor's (DOL) Veterans' Employment and Training Service (VETS) enforces USERRA.

**Health Insurance Portability and Accountability Act of 1996 (HIPAA):** Increased restrictions on patient information confidentiality by creating a standard for patient information sharing. Enforced by U.S. Health and Human Services.

**Pension Protection Act of 2006:** Amendment to Civil Rights Act of 1991. Landmark legislation that strengthens employer funding requirements for employee pension plans and creates a stronger pension insurance system. Enforced by the U.S. Department of Labor.

**National Defense Authorization Act of 2008:** Expanded the FMLA to include families of military service members, which means that an employee may take up to 12 weeks of leave if a child, spouse, or parent has been called to active duty in the armed forces. Enforced by the U.S. Department of Labor.

**Genetic Information Nondiscrimination Act of 2008:** Prohibits U.S. insurance companies and employers from discriminating based on genetic test results. Enforced by the EEOC.

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**Table 2.1** (Continued)

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**Lilly Ledbetter Fair Pay Act of 2009:** An amendment to Title VII of the Civil Rights Act of 1964 that also applies to claims under the Age Discrimination in Employment Act of 1967 and ADA and provides protection for unlawful employment practices related to compensation discrimination. Enforced by the EEOC.

**Patient Protection and Affordable Care Act of 2010 (PPACA):** Controversial legislation that requires individuals to purchase health insurance by 2014. Contested by several states for its constitutionality, provisions of the Act will be reviewed by the Supreme Court in 2012.

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if it is determined their jobs have equal responsibilities and require the same skills. It can be difficult to assess whether two employees are performing the exact same job. One employee may have additional duties, which would affect his or her pay. The current trend in business is pay for performance, so some employees may earn more if they perform better. However, research consistently states that women earn less than men do. An individual who alleges pay discrimination may file a lawsuit without informing the EEOC.

### **Civil Rights Act of 1964, Title VII**

This landmark act prohibits discrimination based on race, sex, color, religion, and national origin. Discrimination means making distinctions among people that are different. This legislation is the key legal piece to equal opportunity employment. Two components to this legislation, which will be discussed later, are disparate treatment and disparate impact. This legislation applies to employers with 15 or more employees. The act is enforced by the Equal Employment Opportunity Commission (EEOC).

The Civil Rights Act of 1964, Title VII, created a concept of protected classes to protect these groups from employment discrimination of compensation, conditions, or privileges of employment. The protected classes include sex, age, national origin, race, and religion. A major current issue under the purview of discrimination legislation is sexual harassment. According to the EEOC, **sexual harassment** is defined as unwelcome sexual conduct that has a negative impact on the employee. There are two major distinctions in sexual harassment: (1) quid pro quo sexual harassment, which occurs when sexual activities occur in return for an employment benefit, and (2) when the behavior of coworkers is sexual in nature and creates an uncomfortable work environment. What is more prevalent in sexual harassment is the creation of a hostile work environment. Several court case judgments indicate that repeated suggestive joke telling or lewd photos on display can be legally constituted as a hostile work environment. In the healthcare industry, nurses experience sexual harassment from colleagues, physicians, and patients.

## **Age Discrimination in Employment Act of 1967**

This act protects employees and job applicants 40 years and older from discrimination as it applies to hiring, firing, promotion, layoffs, training, assignments, and benefits. Older employees file lawsuits for age discrimination in job termination. This legislation applies to employers with 20 or more employees and the act is enforced by the EEOC. During difficult economic times, older employees' complaints of termination increase.

## **Consumer Credit Protection Act (Title III) of 1968**

This act prohibits employers from terminating an employee if the individual's earnings are subject to garnishment due to debt issues. This Act also limits the weekly garnishment amount from the individual's pay. The Act is enforced by the Federal Deposit Insurance Corporation.

## **Occupational Safety and Health Act of 1970**

The OSHA Act of 1970 requires employers to provide a safe and healthy place of employment. It established the Occupational Safety and Health Administration, which collaborates with states on policies for safe work environments.

## **Rehabilitation Act of 1973**

This law applies to organizations that receive financial assistance from federal organizations, including the U.S. Department of Health and Human Services, to prevent discrimination against individuals with disabilities with respect to receipt of employee benefits and job opportunities. These organizations and employers include many hospitals, nursing homes, mental health centers, and human service programs. Employers with 50 or more employees and federal contracts of \$50,000 or more must submit written affirmative action plans. The act is enforced by the Office of Federal Contract Compliance Programs (OFCCP).

## **Employee Retirement Income Security Act of 1974**

The Employee Retirement Income Security Act of 1974 (ERISA) regulates pension and benefit plans for employees, including medical and disability benefits. It protects employees because it forbids employers from firing an employee so that the employee cannot collect under their medical coverage. An employee may change the benefits provided under his or her plan, but employers cannot force an employee to leave so that the employer does not have to pay the employee's medical coverage.

## **Pregnancy Discrimination Act of 1978 (Amendment to CRA 1964)**

This is an amendment to Title VII of the Civil Rights Act of 1964. This act protects female employees that are discriminated against based on pregnancy-related conditions,



which constitutes illegal sex discrimination. A pregnant woman must be treated like anyone with a medical condition. For example, an organization must allow sick leave for pregnant women with morning sickness if they also allow sick leave for other nausea illnesses (Gomez-Mejia et al., 2012). This legislation applies to employers with 15 or more employees and is enforced by the EEOC.

### **Consolidated Omnibus Budget Reconciliation Act of 1986**

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), an amendment to ERISA, was passed to protect employees who lost or changed employers so that they could keep their health insurance if they paid 102% of the full premium (Anderson, Rice & Kominski, 2007b). The act was passed because, at the time, people were afraid to change jobs, resulting in the concept of **job lock** (Emanuel, 2008). COBRA also includes provisions that require hospitals to provide care to everyone who presented at an emergency department, regardless of their ability to pay. Fines were accrued if it was determined that hospitals were refusing treatment (Sultz & Young, 2006). This component was very important because many individuals were refused treatment because they could not pay for the services or were uninsured.

### **Immigration Reform and Control Act of 1988**

The Immigration Reform and Control Act of 1988 requires employers with one or more employees to verify that all job applicants are U.S. citizens or authorized to work in the United States. Most employees are only aware of this legislation because of the I-9 form all new employees must complete. There are three categories, A, B, and C, on the form. Category A establishes identity and eligibility to work such as by a passport, Permanent Resident Card, or Permanent Alien Registration Receipt Card. Category B establishes identity of the individual. Acceptable proof of identify includes a driver's license and different types of identification cards with photographs. Category C focuses on eligibility of an employee to work. Documentation includes a Social Security card or birth certificate. If an employee cannot provide this information, he or she must provide documentation in both Category B and Category C. This prohibits any company from hiring illegal aliens and penalizes employers who hire illegal aliens. However, immigrants with special skill sets or who can satisfy a labor shortage in the United States, such as nurses, will be permitted to work in the United States. This act is enforced by the U.S. Department of Labor.

### **Drug Free Workplace Act of 1988**

This act requires any employers who receive federal grants or who have a federal contract of \$25,000 or greater to certify that they operate a drug-free workplace. They must provide education to their employees about drug abuse. Many employers now offer drug testing. This act is enforced by the U.S. Department of Labor.

## Worker Adjustment and Retraining Notification Act of 1989

Employers who have 100 employees or more must give their employees 60 days notice of layoffs and business closings. This act is enforced by the U.S. Department of Labor.

## Americans with Disabilities Act of 1990

The Americans with Disabilities Act of 1990 (ADA) focuses on individuals who are considered disabled in the workplace. There are three sections: Section I contains employment limitations, and Section II and Section III target local government organizations, hotels, restaurants, and grocery stores. This legislation applies to employers who have 15 employees or more and is enforced by the EEOC. According to the law, a disabled person is someone who has a physical or mental impairment that limits the ability to hear, see, speak, or walk. The act was passed to ensure that those individuals who had a disability but who could perform primary job functions were not discriminated against. According to the act, the disabilities include learning disabilities, mental disabilities, epilepsy, cancer, arthritis, mental retardation, AIDS, asthma, and traumatic brain injury. A nursing home cannot refuse to admit a person with AIDS that requires a nursing service if the hospital has that type of service available (Americans with Disabilities Act of 1990, 2011). Alcohol and other drug abuses are not covered under ADA. Individuals who are morbidly obese can be considered disabled if the obesity was related to a physical cause.

Title I of ADA states that employment discrimination is prohibited against individuals with disabilities who can perform **essential functions** of a job with or without *reasonable* accommodation. Essential functions are job duties that must be performed for an individual to be a satisfactory employee. Reasonable accommodation refers to employers that take reasonable action to accommodate a disabled individual such as providing special computer equipment or furniture to accommodate a physical limitation. The reasonable accommodation should not cause undue financial hardship to the employer.

Individuals with disabilities have mental or physical limitations such as walking, speaking, breathing, sitting, seeing, or hearing. **Intellectual disabilities** refer to an IQ less than 70–75, the disability occurred before 18 years of age, and the individual has issues with social skills. Intellectual disabilities must significantly limit major life activities such as walking, seeing, hearing, thinking, speaking, learning, concentrating, and working. The ADA amendments of 2008 expanded living activities to include bodily functions such as bladder, circulatory, neurologic, and digestive functions.

## Older Workers Benefit Protection Act of 1990 (Amendment to ADEA)

This act amended the Age Discrimination in Employment Act. Its goal was to ensure that older workers' employee benefits were protected and that an organization provided the same benefits to both younger and older workers. The act also gives employees time to decide if they would accept early retirement options and allows employees

to change their mind if they have signed a waiver for their right to sue. This act is enforced by the EEOC.

### **Civil Rights Act of 1991 (Amendment to CRA of 1964)**

Title VII only allowed damages for back pay. This act enables individuals to receive both **punitive damages**, which are damages that punish the defendant, and **compensatory damages** for financial or psychological harm. This legislation applies to employers with 15 or more employees. The size of the damages is based on the size of the company: \$50,000 for employers with 15 to 100 employees; \$100,000 for employers with 101 to 200 employees; \$200,000 for employers with 201 to 500 employees; and \$300,000 for employers with more than 500 employees. This act is enforced by the EEOC.

The 1991 law extended the possibility of individuals collecting damages related to sex, religious, or disability-related discrimination. Organizations had developed a policy of adjusting scores on employment tests so that a certain percentage of a protected class would be hired. This amendment to Title VII specifically prohibits quotas, which are diversity goals to increase the number of a protected class in a workforce (Gomez-Mejia, Balkin & Cardy, 2012). The amendment also created the Glass Ceiling Commission, which examined the lack of protected classes in senior management positions (1991–1996).

### **Family Medical Leave Act of 1993**

The Family Medical Leave Act of 1993 (FMLA) requires employers with 50 or more employees within a 75-mile radius who work more than 25 hours per week and who have been employed more than 1 year to provide up to 12 work weeks of unpaid leave to an employee during any 12-month period so the employee may provide care for a family member or obtain care for himself or herself. This benefit can also include post-childbirth or adoption. The employer must provide healthcare benefits although it is not required to provide wages. This benefit does not cover the organization's 10% highest paid employees. The employer is also supposed to provide the same job or a comparable position upon the return of the employee (Noe, Hollenbeck, Gerhart & Wright, 2009).

### **Health Insurance Portability and Affordability Act of 1996**

The Health Insurance Portability and Affordability Act of 1996 (HIPAA) was passed to promote patient information and confidentiality in a secure environment. Fully implemented in 2003, the amount of health information released is controlled by the consumer. This is the first federal legislation that provides in-depth protection of consumers' health information. Both civil and criminal penalties, including incarceration,

were included in this act. Civil penalties were capped at \$100 per violation and \$25,000 per year. Criminal penalties ranged from \$50,000 to \$250,000 with 1–10 years of incarceration (Stanwyck & Stanwyck, 2009).

HIPAA was an amendment to ERISA and the Public Health Service Act to increase access to healthcare coverage when employees changed jobs. HIPAA made it illegal to obtain personal medical information for reasons other than healthcare activities, which also includes genetic information. It also guaranteed that individuals could purchase health insurance for a preexisting condition if they (1) have been covered by a previous employer program for a minimum of 18 months, (2) have exhausted any coverage through COBRA, (3) are ineligible for other health insurance programs, and (4) were uninsured for no longer than 2 months. Other provisions include (1) small businesses with 2–50 employees cannot be refused insurance, (2) self-employed individuals are allowed an increased tax deduction (30% to 80% by 2006) for health insurance premiums, and (3) employers or insurance companies cannot drop individuals for high usage of their medical plans (Shi & Singh, 2008b). This act is enforced by the U.S. Department of Health and Human Services Office for Civil Rights and by the U.S. Department of Justice.

### **Mental Health Parity Act of 1996**

This act defines the equality or parity between lifetime and annual limits of health insurance reimbursements on both mental health and medical care. Unfortunately, the act did not require employers to offer mental health coverage, it did not impose limits on deductibles or coinsurance payments, nor did it cover substance abuse. This federal legislation spurred several states to implement their own parity legislation (Anderson, Rice & Kominski, 2007b).

### **HIPAA National Standards to Protect Patients' Personal Medical Records of 2002**

This legislation amended the HIPAA, further protecting medical records and other personal health information maintained by healthcare providers, hospitals, insurance companies, and health plans. It gives patients new rights to access of their records, restricts the amount of patient information released, and establishes new restrictions to researchers' access (The Privacy Rule, 2011).

The **Wellstone Act**, or the **Mental Health Parity and Addiction Equity Act of 2008**, amends the Mental Health Parity Act of 1996 to include substance abuse treatment plans as part of group health plans.

### **National Defense Authorization Act of 2008**

This act expanded FMLA to include families of military service members, which means that an employee may take up to 12 weeks of leave if a child, spouse, or parent has

been called to active duty in the armed forces. Additionally, if a service member is injured or ill as a result of active duty, the employee may take up to 26 weeks of leave in a single 12-month leave year (Hickman, Gilligan & Patton, 2008).

## **Genetic Information Nondiscrimination Act of 2008**

This act prohibits U.S. insurance companies and employers from discriminating based on information derived from genetic tests. Specifically, it forbids insurance companies from discriminating through reduced coverage or price increases. It also prohibits employers from making adverse employment decisions based on a person's genetic code. Employers or insurance companies cannot demand a genetic test (National Human Genome Research Institute, 2009).

## **Health Information Technology for Economic and Clinical Health Act of 2009**

Effective September 23, 2009, this act amends HIPAA by requiring stricter notification protocols for breach of any patient information. These new rules apply to any associates of the health plans. It also increased HIPAA's civil and criminal penalties for violating consumer privacy regarding personal health information. Civil penalties were increased to \$1,500,000 per calendar year, which was a huge increase in the original penalty cap of \$25,000. The criminal penalties of up to \$50,000 to \$250,000 and 10 years of incarceration remained the same.

## **Lilly Ledbetter Fair Pay Act of 2009**

This act, an amendment to Title VII of the Civil Rights Act of 1964 that also applies to claims under the Age Discrimination in Employment Act of 1967 and the Americans with Disabilities Act of 1990, provides protection for unlawful employment practices related to compensation discrimination. This act was named after Lilly Ledbetter, an employee of Goodyear Tire and Rubber Company who found out near her retirement that her male colleagues were paid more than she was. The U.S. Supreme Court ruled that she should have filed a suit within 180 days of the date that Goodyear paid her less than her peers. This act allows the statute of limitations to restart every 180 days from the time the worker receives a paycheck (Drachler, 2010).

To avoid litigation, Sedhom (2009) suggests the implementation of a program coordinated by senior management and HR to help protect employers from being accused of unfair employment practices. The following summarizes the steps of the program:

1. Establish compensation criteria.
2. Develop pay audits and document these audits for several years.
3. Document retention processes related to pay.

4. Train managers on providing objective performance evaluations.
5. Develop and implement a rigorous statistical analysis of pay distributions.

## **Patient Protection and Affordability Care Act of 2010**

This healthcare legislation has been controversial. There were national public protests and a huge division among the political parties regarding the components of the legislation. People, in general, agreed that the U.S. healthcare system needed some type of reform, but it was difficult to develop common recommendations that had majority support. Criticism, in part, focused on the increased role of government in monitoring the healthcare system and requiring individuals to obtain health insurance.

The one implementation that has been generally supported is the expansion of the dependent coverage provided by parental health insurance from age 25 until age 26, even if the child is not living with his or her parents, is not declared a dependent on the parents' tax return, is a student, or is no longer a student. This would not apply to individuals who have employer-based coverage (Kolpack, 2010). Another positive mandate, implemented in July 2010, was the establishment of a web portal, [www.healthcare.gov](http://www.healthcare.gov), to increase consumer awareness about eligibility for specific healthcare insurance.

In addition to the two reforms discussed in the previous paragraphs, the following are selected major reforms that were also implemented in 2010:

- Elimination of lifetime and annual caps on healthcare reimbursement.
- Provision of assistance for the uninsured with preexisting conditions.
- Creation of a temporary reinsurance program for early retirees.

In the past, health insurance companies would establish an annual or lifetime cap of reimbursement for the use of healthcare insurance. These would be eliminated. Unlike the past, health insurance companies would also be prohibited from dropping individuals and children with certain conditions or not providing insurance to those individuals with preexisting conditions. The government would provide assistance to securing healthcare insurance for these high-risk individuals.

The following are selected major reforms that will be implemented by 2014:

- Insurance companies will be prohibited from setting insurance rates based on health status, medical condition, genetic information, or other related factors.
- Each state must establish the American Health Benefit Exchange, which is a marketplace where consumers can obtain information and buy health insurance.
- Most individuals must maintain minimum essential healthcare coverage or pay a fine of \$95, \$350 in 2015, \$750 in 2016, and indexed after that year.
- Employers who have 200 or more employees must automatically enroll new full-time employees in healthcare coverage. Employers will also receive tax credits depending on their size.

In the past, there were issues with health insurance companies denying coverage based on health status or other conditions. Premiums now will be based on family type, geography, tobacco use, and age. In addition, each state will establish an American Health Benefit Exchange to assist consumers with obtaining health insurance. Funding is available to states to establish the exchanges within 1 year of enactment of the law, up to January 1, 2015. There will be Public Plan Options and Consumer Operated and Oriented Plans. The Public Plan Option will be a federal contract with insurers to offer two multi-state plans in each exchange of which one plan must be offered by a nonprofit organization. The Consumer Operated and Oriented Plans are member-run health organizations in all 50 states and must be consumer focused with profits targeted to lowering premiums and improving benefits.

The Small Business Option Program will allow small businesses to purchase coverage starting in 2017. The information will be provided to consumers in a standardized format so they can compare the plans. Plans and cost will vary based on level of coverage. There are exceptions based on circumstances. Employers with 200 employees or more must also enroll new employees in a healthcare plan. The purpose of these programs is to increase the number of consumers who have access to affordable health care. By 2014, most consumers will be responsible for obtaining healthcare insurance or pay a fine as described earlier. The PPACA has affected how health insurance companies provide coverage (Niles, 2010).

## **Role of the Equal Employment Opportunity Commission**

The EEOC was created by Title VII of the Civil Rights Act of 1964. It is responsible for processing complaints, issuing regulations, and collecting information from employers. The EEOC collaborates with other federal agencies such as the U.S. Department of Labor to ensure that employees are treated fairly.

### **Processing Complaints**

If an individual feels discriminated against, he or she files a complaint with the EEOC, which, in turn, notifies the employer. The employer is responsible for safeguarding any written information regarding the complaint. The EEOC then investigates the complaint to determine if the employer did violate any laws. If a violation was found, the EEOC uses conciliation or negotiation to resolve the issue without going to court. If conciliation is not successful, litigation or going to trial is the next step. Most employers prefer to avoid litigation because it is costly and damages their reputation. Most cases are resolved by conciliation.

### **Issuing Regulations**

The EEOC is responsible for developing regulations for any EEOC laws and their amendments. They have written regulations and amendments for the ADA, ADEA,

and Equal Pay Act. They also issue guidelines for different issues such as sexual harassment and affirmative action.

An **affirmative action plan** is a strategy that encourages employers to increase the diversity of their workforces by hiring individuals based on race, sex, and age. These potential employees must be qualified for the job. Although an affirmative action plan encourages hiring protected class candidates, an employer cannot set quotas for this process. They can develop strategies to encourage applications by diverse candidates.

An employer who develops an affirmative action plan must perform an analysis of the demographics of the current workforce compared with the eligible pool of qualified applicants. The employer must also calculate the percentage of the protected class among the qualified applicants. The percentages are compared to determine if there is an underrepresentation of diverse employees in the organization. If it is determined that the current workforce is not diverse, then an employer develops a timetable to hire diverse employees, which also includes a recruitment plan.

### Information and Education

The EEOC acquires information from employers regarding their practices. Employers with 100 or more employees must file an EEO-1 report, which reflects the number of women and minorities who hold positions. This report is used to assess any potential discrimination trends. The EEOC also provides written and electronic media education about discrimination to employers. They send this information to the HR departments, which disseminate the information with training classes.

These pieces of legislation focus on equal employment opportunity in the workplace. These laws ensure that protected classes, as outlined in the Civil Rights Act of 1964, are provided opportunities for equal employment without bias or discrimination. In addition to this landmark legislation, the Age in Discrimination Act, Older Workers Benefit Protection Act, and the ADA establish standards for treating individuals who are older than 40 years, and those individuals who have a disability are also treated fairly in their terms of employment. Both the Age in Discrimination Act and the ADA were further strengthened by the passage of the Lilly Ledbetter Fair Pay Act regarding pay discrimination. In addition, the Pregnancy Discrimination Act and the Equal Pay Act target discrimination against women. Despite the number of antidiscrimination pieces of legislation, discrimination continues to exist in the work environment.

The release of patient information is more complex because of the introduction of information technology to the healthcare industry. For example, patient information may be faxed as long as only necessary information is transmitted and safeguards are implemented. Physicians may also communicate via e-mail as long as safeguards are implemented.

### Role of the Occupational Safety and Health Administration

Part of the U.S. Department of Labor, this federal agency is very important to the healthcare industry because of the high incidence of employee injury. It enforces



the regulations of the OSHA of 1970. There is a high risk of exposure to workplace hazards such as airborne and blood-borne infectious diseases, physical injuries from the lifting of patients, and needle-stick injuries. This law was passed to ensure that employers have a **general duty** to provide a safe and healthy work environment for their employees, which is very important for the healthcare industry because of potential exposure to bacteria, viruses, and contaminated fluids. Employers are also required to inform employees of potential hazardous conditions and Occupational Safety and Health Administration (OSHA) standards. Posters and other materials are posted for the education of employees. OSHA is responsible for enforcing these provisions. The National Institute for Occupational Safety and Health (NIOSH) was also established as part of this act to provide research to support the standards. OSHA enforces the **Hazard Communication standard**, which requires companies to label hazardous materials. Information is contained in **Material Safety Data Sheets (MSDSs)**, which are provided to employees via the Internet or on site. OSHA has also issued a standard for exposure to human immunodeficiency virus, hepatitis B virus, and other blood-borne pathogens. This standard is crucial to the healthcare industry because of increased risk of exposure by nurses and laboratory workers.

OSHA has also developed standards for **personal protective equipment**, which mandate equipment to be used in situations of personal exposure to hazardous materials or working conditions. Companies must also maintain records of employee accidents. OSHA provides workers with the rights to receive training, to keep a copy of their medical records, and to request OSHA inspections of their workplace.

OSHA has also developed standards for **ergonomics**, which is the study of working conditions that affect the physical condition of employees. Studies indicate that repetitive motion can create employee injuries. A common disorder is **carpal tunnel syndrome**, which is a wrist injury common to repetitive hand motion that occurs in jobs such as that of grocery cashier and in computer users. Employers can provide ergonomic-friendly equipment and guidelines for ergonomic actions to eliminate these types of injuries. Ergonomic equipment and actions are important to the healthcare industry because many workers often lift patients to and from beds, operating tables, and wheelchairs (OSHA, 2010).

## ■ Basic Concepts of Ethics in the Healthcare Workplace

Ethical standards are considered one level above legal standards because individuals make a choice based on what is the “right thing to do,” or what one ought to do, not what are the minimal actions required by law. There are many interpretations of the concept of ethics. Ethics has been interpreted as the moral foundation for standards of conduct (Taylor, 1975). The concept of **ethical standards** applies to actions that are hoped for and expected by individuals. There are many definitions of ethics but, basically, **ethics** is concerned with what are right and wrong choices as perceived by

society and its individuals. Ethical dilemmas are often a conflict between personal and professional ethics. A **healthcare ethical dilemma** is a problem, situation, or opportunity that requires an individual, such as a healthcare provider, to choose an action between two obligations (Niles, 2010). The dilemma occurs when the ethical reasoning of the decision maker may conflict with the ethical reasoning of the patient and the institution. Dilemmas are often resolved because of the guidelines provided by codes of ethics of medical associations or healthcare institutions, ethics training, and implementation of ethical decision-making models.

According to Beauchamp and Childress (2001) and Gillon (1994), the role of ethics in the healthcare industry is based on five basic values that all healthcare providers should observe:

- **Respect for autonomy:** Decision making may be different, and healthcare providers must respect their patients' decisions.
- **Beneficence:** The healthcare provider should have the patient's best interests in mind.
- **No malfeasance:** The healthcare provider will not cause any harm when taking action.
- **Justice:** Healthcare providers will make fair decisions.
- **Dignity:** Patients should be treated with respect and dignity.

**Autonomy**, which is defined as self-rule, is an important concept to health care because it is applied to informed consent, which requires a provider to obtain the approval of a patient who has been provided adequate information to make a decision regarding intervention. Informed consent is a legal requirement for medical intervention. As part of the autonomy concept, it is also important that the provider respect the decision of the patient even if the patient's decisions do not agree with the provider's recommendation. A friend who has been diagnosed with a very advanced stage of cancer was told by her provider that she could enroll her in an experimental program that would give her 2 to 3 months to live. The intervention is very potent with severe side effects. My friend decided to try a homeopathic medicine to attack her disease. Her doctor was not in agreement with her choice, but she respected her patient's decision. She told her that if she needed pain medication, she could come and see her, and she would help her. This situation is an excellent example of autonomy in medicine.

**Beneficence** means that the best interest of the patient should always be the first priority of the healthcare provider, and **no malfeasance** states that healthcare providers must not take any actions to harm the patient. As discussed in the paragraph on autonomy, the concepts of beneficence and no malfeasance appear to be very easy to understand; however, there may be a difference of interpretation between the provider and the patient as to what is best for the patient. For example, Jehovah's Witnesses, a religious sect, do not believe in blood transfusions and will not give consent during an operation for a transfusion to occur, despite the procedure's ability to possibly save a life (Miller, 2006f). The provider has been trained to believe in beneficence and no

malfiance. However, from the provider’s point of view, if the provider respects the wishes of the patient and family, he or she will potentially be harming the patient.

**Justice** or fairness in health care emphasizes that patients should be treated equally and that health care should be accessible to all. Justice should be applied to the way healthcare services are distributed, which means that healthcare services are available to all individuals. Unfortunately, in the United States, the healthcare system does not provide accessibility to all of its citizens. Access to health care is often determined by the ability to pay either out of pocket or by an employer- or government-sponsored program. In countries with universal healthcare coverage, justice in the healthcare industry is more prevalent.

Ethics in the workplace must be governed by the organizational ethics. Ethics has several individual interpretations, so establishing a code of ethics, developing ethics roundtables, creating a decision model for healthcare dilemmas, and providing ongoing ethical training are tools that both HR and management can use to create an ethical culture.

## ■ Decision Model for Healthcare Dilemmas

Healthcare dilemmas require guidelines to process a solution to the dilemma. Codes of ethics and HR training can assist with a solution. HR training can include a decision-making model that will assist the individual to process the steps in resolving the situation. The following is an adapted version of the steps of the PLUS ethical decision-making model:

1. Identification of the dilemma.
2. Identification of the conflicting ethics of each party.
3. Identification of alternatives to a solution.
4. Identification of the impact of each alternative.
5. Selection of the solution.
6. Evaluation of the solution (PLUS Decision Making Model, 2011).

### Application of PLUS Decision-Making Model

*Healthcare Dilemma* (discussed earlier): An oncologist has a patient who has an advanced stage of melanoma (skin cancer). Prognosis: 3–6 months to live. The oncologist has developed an experimental treatment program that has severe side effects but may give the patient an additional 6 months. The patient prefers alternative remedies for medical treatment such as homeopathic solutions (natural remedies).

**Step 1: Define the problem.** This is the most important part of the process. This step should define the problem and the ultimate outcome of the decision-making process.

**Application:** The problem is the differing views of treatment by both the physician and the patient. The physician does not believe in homeopathic remedies. The ultimate outcome of the decision-making process is to prolong the life of the patient if possible.

**Step 2:** *Identify the alternative(s) to the problem.* List the possible alternatives to the desired outcome. Attempt to identify at least three as a minimum, but five are preferred.

*Alternative 1:* Patient accepts experimental treatment program.

*Alternative 2:* Patient rejects experimental treatment program.

*Alternative 3:* Physician researches homeopathic remedies for patient.

*Alternative 4:* Physician refuses to research homeopathic remedies for patient.

*Alternative 5:* Patient seeks other medical advice from different physician.

*Alternative 6:* Physician refers patient to physician who is expert in homeopathic medicine.

**Step 3:** *Evaluate the identified alternatives.* Discuss the positive and negative impact of each alternative.

*Alternative 1:* Patient accepts experimental treatment program.

Positive: Patient's cancer is eradicated or is in remission.

Negative: Treatment has no impact on cancer. Patient dies.

*Alternative 2:* Patient rejects experimental treatment program.

Positive: Cancer goes into remission.

Negative: Patient dies shortly.

*Alternative 3:* Physician researches homeopathic remedies for patient.

Positive: Physician finds a homeopathic remedy that can be used in conjunction with experimental program. Patient accepts treatment. Cancer is eradicated or goes into remission.

Negative: Physician finds no homeopathic solution that can be used in conjunction with experimental program. Patient refuses treatment. Patient dies shortly.

*Alternative 4:* Physician refuses to research homeopathic remedies for patient.

Positive: Patient believes in physician and agrees to try experimental program. Program is successful.

Negative: Patient cuts ties with physician. Receives no treatment and dies shortly.

*Alternative 5:* Patient seeks other medical advice from different physician.

Positive: Patient finds a physician that agrees with homeopathic remedies. Accepts homeopathic remedies and cancer is eradicated or goes into remission.

Negative: Patient does not find a physician who would help her and dies quickly while trying to find someone.

*Alternative 6:* Physician refers patient to a physician who is an expert in homeopathic medicine.

Positive: Patient is treated with a homeopathic solution that prolongs her life.

Negative: Patient is treated with a homeopathic solution that does not prolong her life.

**Step 4: *Make the decision.*** In the healthcare industry, the decision must include the patient's best interest and his or her values, which can be conflicting at times. However, the patient has the right to make an informed decision about his or her health.

In this instance, alternative 6 is chosen, because the patient believes in homeopathic medicine. The physician who does not believe in natural remedies respected the patient's beliefs, which differed from hers, but she still wanted to help the patient. The physician wanted to be involved in the patient care by supporting the beliefs of her patient.

**Step 5: *Implement the decision.*** Once the decision is made, the physician actually finds a physician referral that would help her patient. The primary physician said she would provide any assistance with pain medication if needed.

**Step 6: *Evaluate the decision.*** An evaluation component of any decision will provide data to assess if the decision was successful in resolving the ethical situation. An evaluation process for this model would be to assess the success of the chosen treatment. Success parameters would be the longevity of the patient's life or the quality of the life of the patient.

This was an actual case. The patient accepted the referral of the new physician and entered a homeopathic treatment program. The patient lived 3 more years with a high quality of life. This decision-making model is an excellent method of resolving many types of healthcare dilemmas. This model can be used in HR training on ethical issues in the healthcare workplace.

## ■ Codes of Ethics and the Doctor–Patient Relationship

The foundation of health care is the relationship between the patient and physician. As a result of many public ethical crises that have occurred, particularly in the business world, many organizations have developed codes of ethics. **Codes of ethics** provide a standard for operation so that all participants understand that if they do not adhere to this code, there may be negative consequences. The healthcare industry is no different. Physicians have been guided by many healthcare codes of ethics. The American Medical

Association, the professional membership organization for physicians, created a Code of Medical Ethics for physicians in 1847, which has been updated over the years. In 2001, the Code of Medical Ethics was amended to include the following: provide competent medical care, uphold professional standards, respect the law, respect the rights of patients and colleagues, maintain a commitment to medical education, support public health activities, regard patient care as the primary goal, and support medical care access for all individuals (Medical Ethics, 2011). In 2000 and 2001, the **American College of Physicians and Harvard Pilgrim Health Care Ethics Program** developed a statement of ethics for managed care. The following is a summary of the statements:

- Clinicians, healthcare plans, insurance companies, and patients should be honest in their relationship with each other.
- These parties should recognize the importance of the clinician and patient relationship and, in addition, its ethical obligations.
- Clinicians should maintain accurate patient records.
- All parties should contribute to developing healthcare policies.
- The clinician's primary duty is the care of the patient.
- A clinician has the responsibility to practice effective and efficient medicine.
- Clinicians should recognize that all individuals, regardless of their position, should have health care.
- Healthcare plans and their insurers should openly explain their policies regarding reimbursement of types of health care.
- Patients have a responsibility to understand their health insurance.
- Healthcare plans should not ask clinicians to compromise their ethical standards of care.
- Clinicians should enter agreements with healthcare plans that support ethical standards.
- Confidentiality of patient information should be protected.
- Clinicians should disclose conflicts of interest to their patients.
- Information provided to patients should be clearly understood by the patient (Povar et al., 2004).

This statement was developed as a result of the continued economic and policy changes in the healthcare industry. It provided guidelines to healthcare practitioners, to healthcare organizations, and to the healthcare insurance industry about ethical actions in the changing healthcare environment.

## ■ Other Healthcare Codes of Ethics

Each type of healthcare professional generally has a code of conduct. The American Nurses Association established a code for nurses in 1985, which was revised in 1995 and most recently in 2001 (American Nurses Association, 2011). Healthcare executives

have a code of ethics that was established in 1941 that describes the relationship with their stakeholders and that was most recently updated in 2007. The American College of Healthcare Executives represents 30,000 executives internationally who participate in the healthcare system. They established a code of ethics in 1941, which was most recently updated in 2007. They also offer ethical policy statements on relevant issues such as creating an ethical culture for employees. They also offer an ethics self-assessment tool that enables employees to target potential areas of ethical weakness. Many hospitals have also established codes of ethics to help providers when they are dealing with healthcare dilemmas (American College of Healthcare Executives, 2010).

## ■ How to Develop a Code of Ethics

A code of ethics must be written clearly because employees at all organizational levels will use it. If a certain employee category needs a specific code of ethics, then a written code should be specifically developed for that category. The code must be current in laws and regulations. Driscoll and Hoffman (2000) recommend the following outline for developing a code of ethics:

1. Memorable title
2. Leadership letter
3. Table of contents
4. Introduction
5. Core values of the organization
6. Code provisions
7. Information and resources

The code of ethics must be a user-friendly resource for the organization. It should be updated to include current laws and regulations. The language should be specific as to what the organization should expect from its employees. The organization should provide training on the code of ethics so employees understand the organization's expectations.

## ■ Ethics and Research

The conduct of research involving human subjects requires assessment of the risks and benefits to the human subjects, which must be explained clearly to them before the consent to participate in the research is given. The principles of ethical research are monitored by **institutional review boards** (IRBs). An IRB is a group that has been formally designated to review and monitor medical research involving human subjects. An IRB has the authority to approve, require modifications in (to secure approval), or disapprove research. This group review serves an important role in the protection

of the rights and welfare of human research subjects (Food and Drug Administration, 2009). Any organization that performs research should develop an IRB for their organization. The ethical component of an IRB is to protect the participants of the study. IRBs require researchers to minimize the risks and maximize the benefits to the participant and to explain these assessments clearly. It is important that an IRB not approve a study that imposes significant risks on the subjects.

Assuming the study clears the IRB's assessment of risks and benefits, it is important that the subject understands the study and its impact on him or her. **Research informed consent** is one of the basic ethical protections for human subject research. Informed consent protects human subjects because it allows the individual to consider personal issues before participating in medical research. Informed consent increases autonomy because it provides the individual with the opportunity to make a choice to exercise control over his or her life by disclosing the appropriate information to inform the individual involved in project participation (Mehlman & Berg, 2008). Both the U.S. Department of Health and Human Services and the Food and Drug Administration have outlined common rule regulations that comprise the elements of informed consent.

**Common rule** elements include a written statement that includes the purpose and duration of the study, the procedures and if they are experimental, any foreseen risks and potential benefits, and any alternative procedures that may benefit the subject (Food and Drug Administration, 2009; Korenman, 2009). Additional requirements are needed for children, pregnant women, people with disabilities, mentally disabled people, prisoners, and so forth. It is clear that the IRB must provide guidelines for parents that have children participating in research and for those subjects that may be mentally disabled who could be unduly influenced (Mehlman & Berg, 2008). It is important that all researchers be trained in IRB protocols to protect themselves, the participants, and the organization.

## ■ Workplace Bullying—An International Issue

In 1992, Andrea Adams, a BBC journalist, coined the term “workplace bullying” to describe an ongoing harassing workplace behavior between employees, which can result in negative outcomes for the targeted employees (Adams, 1992). Workplace bullying is receiving increased attention worldwide as a negative organizational issue. It is considered a serious and chronic workplace stressor that can lead to diminished work productivity and work quality (Namie & Namie, 2009). Although the definitions are similar worldwide, there are different labels of bullying that are used—mobbing is used in France and Germany, harassment in Finland, and in the United States and Australia, aggression, emotional abuse, or workplace bullying (Sheehan, 1999; Keashly, 2001). Research in Scandinavian countries indicates that bullying prevalence rates range



from 3.5% to 16%, with United Kingdom research reporting higher prevalence rates (Privitera, Psych & Campbell, 2009).

This negative behavior is considered bullying if it is repeated over an extended period of time. It can occur between colleagues, supervisors, or supervisees, although the bully is often the supervisor. Definitions also include negative verbal or nonverbal behavior such as snide comments, verbal or physical threats, or items being thrown. Employees have also reported less aggressive behavior such as someone demeaning their work or gossiping about them on a continual basis. The literature has reported an increased incidence of bullying reported in healthcare organizations and in academe (Vartia, 2001; Ayoko, Callan & Hartel, 2003; Djurkovic, McCormack & Casimir, 2008).

## **Workplace Bullying in Health Care**

Workplace bullying is common in health care. Specifically, there are bullying issues between physicians and nurses. A 2004 survey by the Institute for Safe Medication Practices indicated that of the 2,095 respondents, which included nurses, pharmacists, and other providers, more than 50% were verbally abused by physicians when asking for clarification regarding prescription orders. The Center for American Nurses, American Association of Critical-Care Nurses, International Council of Nurses, and National Student Nurses Association have all issued statements regarding the need for healthcare organizations to stop bullying in the healthcare workplace. Often, verbal abuse also occurs toward nurses by physicians, patients, and families of patients. **Lateral violence** also occurs in health care, which is defined as “nurse to nurse” aggression, demonstrated by both verbal and nonverbal behavior (Lateral Violence and Bullying in the Workplace, 2011).

## **Workplace Bullying Institute**

The Workplace Bullying Institute was started in the 1990s in the United States by Dr. Gary and Ruth Nanie as a result of Ruth being bullied in her workplace by a female supervisor. They established a website (<http://www.workplacebullying.org>) in 2002 as a venue to promote and educate the public on workplace bullying. In August 2007, they conducted the first study of all adult Americans on workplace bullying—the results indicating that workplace bullying was a major organizational issue. Approximately 8,000 respondents, representative of the U.S. adult population, indicated that 37% of the workers were bullied. Approximately 70% of the bullying was from supervisors with 60% of those bullies being women. The women bullies targeted women in 71% of the cases. According to the survey, more than 60% of the employers ignored the problem. It was also reported by 45% of those who were bullied that they experienced stress-related health problems such as anxiety, depression, and

panic attacks (Workplace Bullying, 2011). These results are consistent with reports from the literature.

## **Impact of Workplace Bullying**

As indicated earlier, workplace bully targets can experience a range of physical and psychological symptoms such as work stress anxiety, lowered job satisfaction and loyalty to the organization, increase in absenteeism, lowered work productivity, and depression (Ayoko et al., 2003). A sense of powerlessness is often reported by the target. In order for a bully to be successful, the target must feel that he or she cannot defend himself or herself against the bully, which allows the bully to continue the behavior. In two Australian studies, more than 40% of the employees were bullied by their supervisors, more than 10% were bullied by their peers, and 2% were bullied by their subordinates (Ayoko et al., 2003).

Workplace bullying also affects other employees because if the bullying continues and is not addressed by management, it affects the overall morale of the workforce. Low morale often results in high employee turnover, which can be detrimental to the organization's success. It also can disrupt the professional career of the target as well as the personal life of the target. From an organizational perspective, continued bullying may result in the organization paying for litigation fees, counseling, workers' compensation, and early retirement payouts (Kieseker & Merchant, 1999).

## **Legal Implications of Workplace Bullying**

Unfortunately, 80% of workplace bullying incidents is not illegal. There is no specific legislation in the United States that forbids workplace bullying. Thirteen states have introduced bills. New York is the only state that has enacted legislation that forbids this type of behavior in the workplace. There are two federal laws that can be applied in workplace bullying: the Occupational Safety and Health Act of 1970 and Title VII of the Civil Rights Act of 1964. Under the Occupational Safety and Health Act of 1970, the employer must provide a safe and healthful working environment for its employees. Under Title VII of the Civil Rights Act, if a protected class employee (gender, religion, ethnicity, etc.) is bullied by another employee, the action can be illegal based on the concept of a hostile work environment, which is illegal under sexual harassment.

## **Recommendations to Eliminate Workplace Bullying**

To date, there is no federal legislation that specifically addresses workplace bullying. To reduce the prevalence of workplace bullying, it is important that employers implement policies to eliminate this behavior. The following are recommendations for organizations including healthcare organizations:

1. Adopt a policy of zero tolerance for workplace bullying and develop measures to discipline bullies in the workplace.

2. Create an organizational culture that focuses on a positive work environment enabling all individuals to pursue their careers.
3. Reward behaviors that encourage teamwork and collaboration among employees and their supervisors.
4. Develop an educational program for all employees on what constitutes workplace bullying (LaVan & Martin, 2007).

Workplace bullying continues to be a pervasive organizational problem worldwide. In the United States, the Workplace Bullying Institute has developed a Healthy Workplace Bill that precisely defines workplace bullying and extends protection to employees against this type of behavior. The bill has been introduced in 14 states since 2003. There is no specific federal legislation against bullying, so bullying will unfortunately continue to be legal. It is important that workplace bullying educational programs and organizational policies be implemented to ensure that employees will be protected against this type of negative behavior. The results can be devastating from both an organizational and individual level.

In 2008, the Joint Commission developed a standard for workplace bullying that they call intimidating and disruptive behaviors in the workplace. They issued the following statement:

Intimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators, and managers to seek new positions in more professional environments. Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team.

Two leadership standards are now part of the Joint Commission's accreditation provisions: The first requires an institution to have "a code of conduct that defines acceptable and disruptive and inappropriate behaviors." The second requires an institution "to create and implement a process for managing disruptive and inappropriate behaviors" (Yamada, 2011).

In a recent Joint Commission study, it was found that more than 50% of nurses have suffered some type of bullying, with 90% observing some type of abuse. Their standard focused on the impact of these types of behavior on patient care quality. The Joint Commission requires healthcare institutions to create a code of conduct that defines appropriate behavior and has a system in place to manage inappropriate behavior such as workplace bullying. In addition to the stance of the Joint Commission, the Center for Professional Health at the Vanderbilt University Medical Center has developed a program for treating and remediating disruptive behaviors by physicians. Nurses' unions are also developing education programs on workplace bullying (Minding the Workplace, 2011).

## ■ Conclusion

The HR department must provide training for all employees to ensure that they understand the seriousness of violating the law and understand the differences between civil and criminal law and the penalties that may be imposed for breaking those laws. Both federal and state laws have been enacted and policy has been implemented to protect both the healthcare provider and the healthcare consumer. New laws have been passed and older laws have been amended to reflect needed changes regarding health care to continue to protect its participants.

In the healthcare industry, there are several areas of operation that are affected by ethics. Healthcare ethical dilemmas develop between providers and patients when there may be a conflict of personal ethical standards. If research is performed by an organization and its employees, IRB training must be implemented to ensure that ethical guidelines are followed when performing research on humans.

Workplace bullying has become an international workplace issue. At this time, there is no federal mandate that targets this type of behavior. Statistics indicate that this behavior is occurring in the healthcare workplace. HR training must target this type of unethical behavior. Developing and enforcing a code of ethics provides a standard for operation so that all participants understand that if they do not adhere to this code, there may be negative consequences.

## ■ Vocabulary

Affirmative action plan	Common rule
Age Discrimination in Employment Act of 1967	Compensatory damages
American College of Physicians and Harvard Pilgrim Health Care Ethics Program	Consolidated Omnibus Budget Reconciliation Act
Americans with Disabilities Act	Criminal law
Assault	Defensive medicine
Autonomy	Employee Retirement Income Security Act
Battery	Equal Pay Act
Beneficence	Ergonomics
Carpal tunnel syndrome	Essential functions
Civil law	Ethical standards
Civil Rights Act of 1964	Ethics
Civil Rights Act of 1991	Family Medical Leave Act
Codes of ethics	General duty
Common law	Genetic Information Nondiscrimination Act

Hazard Communication standard	Older Workers Benefit Protection Act
Health care ethical dilemma	Patient Protection and Affordable Care Act
Health Insurance Portability and Accountability Act	Pension Protection Act
HIPAA National Standards	Personal protective equipment
Informed consent	Pregnancy Discrimination Act
Intellectual disabilities	Punitive damage
Intentional torts	Rehabilitation Act
Institutional review boards	Research informed consent
Invasion of privacy	Rules and regulations
Job lock	Sexual harassment
Justice	Standard of care
Lateral violence	Statutes
Law	Tort reform
Lilly Ledbetter Fair Pay Act	Torts
Material Safety Data Sheets	Uniformed Services Employment and Reemployment Rights Act
Medical malpractice	Voluntary hospital
Mental Health Parity Act	Wellstone Act
Monetary cap	Worker Adjustment and Retraining Notification Act
National Defense Authorization Act	Workplace bullying
Negligence	
No malfeasance	
Occupational Safety and Health Act	

## ■ References

- Adams, A. (1992). *Bullying at Work*. London, UK: Vrago Press, pp. 1–20.
- American College of Healthcare Executives Code of Ethics (2011). Available at: <http://www.advamed.org/MemberPortal/About/code/>. Accessed February 2, 2011.
- American Heritage Dictionary* (2000). Boston, MA: Houghton Mifflin, p. 1060.
- American Medical Association* (2010). Code of Ethics. Available at: <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/>. Accessed November 10, 2010.
- American Nurses Association (2011). Nursing World. Available at: <http://www.nursingworld.org/MainMenuCategories/EthicsStandards.aspx>. Accessed January 5, 2011.
- Americans with Disabilities Act of 1990 (2011). Available at: <http://www.ada.gov/pubs/ada.htm>. Accessed December 3, 2011.
- Anderson, R., Rice, T., & Kominski, G. (2007). *Changing the U.S. Healthcare system*. San Francisco, CA: Jossey-Boss.
- Ayoko, O., Callan, V. & Hartel, C. (2003). Workplace conflict, bullying and counterproductive behaviors. *International Journal of Organizational Analysis*, 11:283–301.

- Beauchamp, T. & Childress, J. (2001). *Principles of Biomedical Ethics* (5th ed.). Oxford, UK: Oxford University Press.
- Buchbinder, S. & Shanks, N. (2007). *Introduction to Health Care Management*. Sudbury, MA: Jones & Bartlett Learning, p. 347–48.
- Danzon, P. (1995). *Medical Malpractice: Theory, Evidence, and Public Policy*. Cambridge, MA: Harvard University Press.
- Department of Labor. (2011). Available at: <http://www.dol.gov/ebsa/Regs/fedreg/final/2006009557.htm>. Accessed June 1, 2011.
- Djurkovic, N., McCormack, D. & Casimir, G. (2008). Workplace bullying and intention to leave: The modernizing effect of perceived organizational support. *Human Resource Management Journal*, 18(4):405–420.
- Drachler, D. (2010). Notes on: Year one of the Lilly Ledbetter Fair Pay Act. *Labor Law Journal*, Summer 2010:102–106.
- Driscoll, D. & Hoffman, W. (2000). *Ethics Matters: How to Implement Values-Driven Management*. Waltham, MA: Center for Business Ethics at Bentley College, pp. 70–80.
- Einarsen, S., Hoel, H., Zapf, D. & Cooper, C. L. (2003). The concept of bullying at work: the European tradition. In: *Bullying and Emotional Abuse in the Workplace: International Perspectives in Research and Practice*. 1st ed. London: Taylor & Francis, p 3-30.
- Emanuel, E. (2008). *Health Care Guaranteed*. New York, NY: Public Affairs.
- Food and Drug Administration (2009). Information Sheet Guidance for Institutional Review Boards, Clinical Investigators, and Sponsors. Available at: <http://www.fda.gov/oc/ohrt/irbs/facts.html#IRBOrg>. Accessed November 4, 2010.
- Gillon, R. (1994) Principles of medical ethics. *British Medical Journal*, 309:184.
- Gomez-Mejia, L., Balkin, D. & Cardy, R. (2012). *Managing Human Resources*. Upper Saddle River, NJ: Pearson, pp. 100–125.
- Hickman, J., Gilligan, M. & Patton, G. (2008). FMLA and benefit obligations: New rights under an old mandate. *Benefits Law Journal*, 21(3):5–16.
- Keashly, L. (2001). Interpersonal and systemic aspects of emotional abuse at work: The target's perspective. *Violence and Victims*, 16:233–268.
- Kieseker, R. & Merchant, T. (1999). Workplace bullying in Australia: A review of current conceptualizations and research. *Australian Journal of Management and Organizational Behavior*, 2: 61–75.
- Kolpack, D., (2010). PPACA's adult child coverage requirement clarified. Available at: <https://www.bcbsnd.com/blueinsight/2010/04/12/ppaca%E2%80%99s-adult-child-coverage-requirement-clarified/>. Accessed December 3, 2011.
- Korenman, S. G. (2010). Teaching the responsible conduct of research in humans. Available at: <http://ori.hhs.gov/education/products/ucla/chapter2/page04b.htm>. Accessed November 4, 2010.
- Lateral Violence and Bullying in the Workplace (2011). Available at: <http://www.tnaonline.org/Media/pdf/wkpl-viol-dec-10-can-conflict-bully-fact-sheet.pdf>. Accessed December 3, 2011.
- LaVan, H. & Martin, W. (2007). Bullying in the U.S. workplace: Normative and process-oriented ethical approaches. *Journal of Business Ethics*, 83:147–165.
- Medical Ethics (2011). Available at: <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page?>. Accessed July 7, 2011.
- Medical Negligence: The role of America's civil justice system in protecting patient rights (2011). American Association for Justice. Available at: <http://www.kff.org/insurance/upload/Medical-Malpractice-Law-in-the-United-States-Report.pdf>. Accessed December 3, 2011.

- Mehlman, M. & Berg, J. (2008). Human subjects' protections in biomedical enhancement research: Assessing risk and benefit and obtaining informed consent. *Journal of Law, Medicine & Ethics*, Fall:546–559.
- Miller, R. (2006a). *Problems in Health Care Law* (9th ed.). Sudbury, MA: Jones and Bartlett Publishers, p. 1.
- Miller, R. (2006b). *Problems in Health Care Law* (9th ed.). Sudbury, MA: Jones and Bartlett Publishers, p. 686.
- Miller, R. (2006c). *Problems in Health Care Law* (9th ed.). Sudbury, MA: Jones and Bartlett Publishers, p. 605.
- Miller, R. (2006d). *Problems in Health Care Law* (9th ed.). Sudbury, MA: Jones and Bartlett Publishers, p. 586.
- Miller, R. (2006e). *Problems in Health Care Law* (9th ed.). Sudbury, MA: Jones and Bartlett Publishers, p. 587.
- Miller, R. (2006f). *Problems in Health Care Law* (9th ed.). Sudbury, MA: Jones and Bartlett Publishers, p. 341.
- Minding the Workplace (2011). Available at: <http://newworkplace.wordpress.com/2009/12/15/workplace-bullying-in-healthcare>. Accessed June 10, 2011.
- Namie, G. & Namie, R (2009). U.S. workplace bullying: Some basic considerations and consultation interventions. *Consulting Psychology Journal*, 61 (3), 202–219. National Human Genome Research Institute (2011). Available at: <http://www.genome.gov/About/>. Accessed March 1, 2011.
- Nelson III, L., Morrissey, M. & Kilgore, M. (2007). Damages caps in malpractice cases. *The Milbank Quarterly*, 85(2):259–286.
- Niles, N. (2010). *Basics of the U.S. Health Care System*. Sudbury, MA: Jones & Bartlett, pp. 247–259.
- Noe, R., Hollenbeck, J., Gerhart, B. & Wright, P. (2009). *Fundamentals of Human Resource Management* (3rd ed.). Boston, MA: McGraw-Hill/Irwin.
- Occupational Safety & Health Administration (2010). *Ergonomics*. Retrieved from <http://www.osha.gov/SLTC/ergonomics/>. Accessed April 1, 2011.
- Office of Technology Assessment (1993). *Impact of Legal Reforms on Medical Malpractice Cost*, OTA-BP-H-19. Washington, DC: U.S. Government Printing Office.
- PLUS Decision Making Model (2011). Available at: <http://www.ethics.org/resource/plus-decision-making-model>. Accessed September 22, 2011.
- Povar, C., Blumen, H., Daniel, J., Daub, S., Evans, L., Holm, R., et al. (2004). Ethics in practice: Obama, Task Force call on Senate to pass Paycheck Fairness Act. *Bureau of National Affairs*, September 2010:11–14.
- Privitera, C., Psych, M. & Campbell, M. (2009). Cyberbullying: The new face of workplace bullying? *Cyber Psychology & Behavior*, 12(4):395–400.
- Rosenbach, M. & Stone, A. (1990). Malpractice insurance costs and physician practice—1981–1986. *Health Affairs*, 9:176–185.
- Sedhom, S. (2009). Reacting to the Lilly Ledbetter Fair Pay Act: What every employer needs to know. *Employee Relations Law Journal*, 35(3):3–8.
- Sheehan, M. (1999). Workplace bullying: Responding with some emotional intelligence. *International Journal of Manpower*, 20(1/2):57–69.
- Shi, L. & Singh, D. (2008a). *Essentials of the U.S. Health Care Delivery System*. Sudbury, MA: Jones and Bartlett Publishers, p. 17.

- Shi, L. & Singh, D. (2008b). *Essentials of the U.S. Health Care Delivery System*. Sudbury, MA: Jones and Bartlett Publishers, p. 227.
- Stanwyck, P. & Stanwyck, S. (2009). *Understanding Business Ethics*. Upper Saddle River, NJ: Pearson Prentice Hall, pp. 110–112.
- Sultz, H. & Young, K. (2006). *Healthcare USA: Understanding its organization and delivery*. Sudbury, MA: Jones and Bartlett Publishers.
- Taylor, P. (1975). *Principles of Ethics: An Introduction to Ethics* (2nd ed.). Encino, CA: Dickinson.
- The Privacy Rule (2011). Available at: <http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/index.html>. Accessed December 3, 2011.
- Vartia, M. (2001). Consequences of workplace bullying with respect to the well-being of its targets and the observers of bullying. *Scandinavian Journal of Work Environment and Health*, 27:63–59.
- Waters, T., Budetti, P., Claxton, G. & Lundy, J. (2007). Impact of state tort reforms on physician malpractice payments. *Health Affairs*, 26(2):500–509.
- Workplace Bullying (2011). Available at: <http://www.workplacebullying.org>. Accessed July 7, 2011.
- Wynia, M. (2007). Ethics and public health emergencies: Encouraging responsibility. *The American Journal of Bioethics*, 7:1–4.
- Yamada, D. (2011). *Workplace Bullying in Healthcare: The Joint Commission Standards*. Available at: <http://newworkplace.wordpress.com/2009/12/15/workplace-bullying-in-healthcare-i-the-joint-commission-standards/>. Accessed September 23, 2011.





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## **Real-Life Applications: Case Scenario 2**

The CEO of your managed care organization has asked you to discuss the importance of ethics in the workplace. He has requested that you develop mandatory ethics training for all employees. Your CEO specifically asked that you address any ethics codes that target managed care.

### ***Activity***

Devise an ethics training that includes healthcare codes of ethics for managed care. Also, suggest five ways to improve ethics in the managed care organization.

### ***Responses***

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## STUDENT WORKBOOK ACTIVITY 2.2

### In Your Own Words

Based on this chapter, please provide an explanation of the following concepts in your own words as they apply to human resource management. *Do not recite* the text.

Criminal law:

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Civil law:

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Healthcare ethical dilemma:

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Autonomy:

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Workplace bullying:

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Torts:

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Lateral violence:

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Job lock:

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Defensive medicine:

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## STUDENT WORKBOOK ACTIVITY 2.3

### Internet Exercises

Write your answers in the spaces provided.

- Visit each of the websites listed in the text that follows.
- Name the organization.
- Locate its mission statement on its website.
- Provide a brief overview of the activities of the organization.
- Apply this organization to the chapter information.

#### **Websites**

**<http://www.justice.gov>**

Organization name:

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Mission statement:

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Overview of activities:

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Application to chapter information:

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**<http://www.genome.gov>**

Organization name:

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Mission statement:

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Overview of activities:

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Application to chapter information:

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**<http://www.healthlaw.org>**

Organization name:

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Mission statement:

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Overview of activities:

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Application to chapter information:

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**<http://www.eeoc.gov>**

Organization name:

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Mission statement:

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Overview of activities:

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Application to chapter information:

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**<http://www.workplacebullying.org>**

Organization name:

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Mission statement:

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Overview of activities:

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Application to chapter information:

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**<http://www.abanet.org>**

Organization name:

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Mission statement:

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Overview of activities:

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Application to chapter information:

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## **STUDENT ACTIVITY 2.4: DISCUSSION BOARDS FOR ONLINE, HYBRID, AND TRADITIONAL ONGROUND CLASSES**

### **Discussion Board Guidelines**

The discussion board is used in online and web-enhanced courses in place of classroom lectures and discussion. The board can be an enhancement to traditional onground classes. The discussion board is the way in which the students “link together” as a class. The following are guidelines to help focus on the discussion topic and to define the roles and responsibilities of the discussion coordinator and other members of the class. The educator will be the discussion moderator for this course.

1. The educator will post the discussion topic and directions for the upcoming week. These postings should all be responses to the original topic or responses to other students’ responses. When people respond to what someone else has posted, they should start the posting with the person’s name so it is clear which

message they are responding to. A response such as “Yes” or “I agree” does not count for credit. Your responses must be in your own words. You cannot copy and paste from the text.

2. Postings (especially responses) should include enough information so the message is clear but should not be so long that it becomes difficult to follow. Remember, this is like talking to someone in a classroom setting. The postings should reflect the content of the text or other assignments. If you retrieve information from the Internet, the hyperlink must be cited.
3. Students should check the discussion daily to see if new information has been posted that requires their attention and response.

Good discussion will often include different points of view. Students should feel free to disagree or “challenge” others to support their positions or ideas. All discussions must be handled in a respectful manner. The following are discussion boards for this chapter.

### ***Discussion Boards***

1. Discuss the concepts of negligence and intentional torts, and give examples of these in the healthcare industry.
2. What is tort reform? Do you believe tort reform is necessary?
3. Discuss three employment-related pieces of legislation that you believe are very important and why.
4. What is your definition of ethics? What do you think are some unethical situations in the healthcare industry?

