



CHAPTER 2

Ethical, Legal, and Economic Foundations of the Educational Process

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CHAPTER HIGHLIGHTS

- A Differentiated View of Ethics, Morality, and the Law
- Evolution of Ethical and Legal Principles in Health Care
- Application of Ethical Principles to Patient Education
 - *Autonomy*
 - *Veracity*
 - *Confidentiality*
 - *Nonmaleficence*
 - *Beneficence*
 - *Justice*
- The Ethics of Education in Classroom and Practice Settings
 - *The Student-Teacher Relationship*
 - *The Patient-Provider Relationship*
- Legality of Patient Education and Information
- Legal and Financial Implications of Documentation
- Economic Factors in Healthcare Education: Justice and Duty Revisited
- Financial Terminology
 - *Direct Costs and Indirect Costs*
 - *Cost Savings, Cost Benefit, and Cost Recovery*
- Program Planning and Implementation
- Cost-Benefit Analysis and Cost-Effectiveness Analysis
- State of the Evidence

KEY TERMS

autonomy	decision aids	malpractice
beneficence	direct costs	moral values
code of ethics	ethical	negligence
confidentiality	ethical dilemmas	nonmaleficence
cost benefit	ethics	practice acts
cost recovery	fixed costs	respondeat superior
cost savings	hidden costs	revenue generation
cost-benefit analysis	indirect costs	variable costs
cost-benefit ratio	justice	veracity
cost-effectiveness analysis	legal rights and duties	

OBJECTIVES

After completing this chapter, the reader will be able to:

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

Approximately 45 years ago, the field of modern Western bioethics arose in response to the increasing complexity of medical care and decision making. Novel challenges in health care continually stem from such influences as technological advances, changes in laws, and public awareness of scientific endeavors. The field of bioethics provides systematic theoretical and practical approaches for handling such complex issues and the dilemmas that ensue from them. As a result, programs of study for nursing and the other health professions now provide formal ethics education—some by mandate. Healthcare providers who commit ethical infractions while in training or practice may be referred for ethics remediation by their programs or specialty licensing boards or may risk professional sanctions.

In the popular media, bioethics translates into stem cell research, organ transplantation, genetic testing, and other sensational innovations. But every day, far from the spotlight, patients, nursing students, and nursing staff, as well as the educators who teach them, confront commonplace and vexing ethical dilemmas. Consider a patient who refuses a routine but lifesaving blood transfusion. Should they be allowed to refuse this treatment, or should the nursing staff persuade the patient otherwise? Suppose a nurse witnesses a confused patient signing a consent form for a procedure. Should they ask whether the patient is able to make the decision to agree to have the procedure done? Or suppose a surgeon misleads a family by indicating that a surgical error was really a complication. Should the nurse practitioner

who observed the error speak to a superior in the healthcare hierarchy? What about a clinical nursing instructor who habitually introduces a nursing student to patients as a nurse, implying that the student has completed their program of study? Should the nursing student correct the faculty member, and, if so, when, where, and how?

These scenarios describe not only practice issues but also moral problems. They happen so frequently that convening an ethics committee to address every one of them is impractical. Increasingly, staff nurses, clinical educators, and nursing students are being called upon to reason through both medical and ethical issues. However, knowledge of basic ethical principles and concepts does not always suffice. According to Wintrup (2015), providing healthcare professionals with a structured ethics education that focuses on moral agency would help to provide better care and outcomes to patients in the acute care setting. This idea of a structured ethics education is also supported by Kim et al. (2020), who used the ADDIE (Analysis, Design, Development, Implementation, and Evaluation) model to implement an ethics education program for nurses.

As the healthcare field has developed, so has a critical consciousness of individual rights stemming from both natural and constitutional law. Healthcare organizations are laden with laws and regulations ensuring clients' rights to a high-quality standard of care, to informed consent, and subsequently to self-determination. Further, in the interest of justice, it is worthwhile to acknowledge the relationship between costs to the healthcare facility and the provision of health services.

Although the physician is primarily held legally accountable for prescribing the medical regimen, it is a known fact that patient education generally falls to the nurse. Indeed, given the close relationship of the nurse to the client, the role of the nurse in this educational process is essential in providing safe, high-quality

care as mandated in the standards and scope of nursing practice through each state nurse practice act and each state's board of nursing (Russell, 2012). Furthermore, the American public, according to the annual Gallup Poll, ranked registered nurses for the 18th consecutive year as the professionals with the highest honesty and ethical standards. Nursing is the most trusted among all other professions (Reinhart, 2020).

Today's enlightened consumers are aware of and demand recognition of their individual constitutional rights regarding freedom of choice and self-determination. In fact, it may seem strange to some that federal and state governments, accrediting bodies, and professional organizations find it necessary to legislate, regulate, or provide standards and guidelines to ensure the protection of human rights in matters of health care. The answer, of course, is that the federal government, which once had an historical hands-off policy toward the activities of physicians and other health professionals, has now become heavily involved in the oversight of provider practices. This is because of serious breaches of public confidence that resulted from shocking revelations of abuses of human rights in the name of biomedical research, which were first discovered in the mid-20th century. Unfortunately, human rights violations continue to occur in health care to this day in the United States and worldwide.

These issues of human rights are fundamental to the delivery of high-quality healthcare services. They are equally fundamental to the education process, in that the intent of the educator should be to empower the client to identify and articulate their values and preferences; acknowledge their role in a family, community, or other relationship; and make well-informed choices, reasonably aware of the alternatives and consequences of those choices. In addition, it is essential that nurses be proficient in educating the staff and students who are or will be the practitioners and educators of tomorrow (Bingham & Quinn, 2017;

Butts & Rich, 2020; Dowd, 2018; Mason et al., 2020). Thus, an interpretation of the role of the nurse in the teaching–learning process must include the ethical and legal foundations of that process. Teaching and learning principles, with their inherent legal and ethical dimensions, apply to any situation in which the education process occurs.

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

A Differentiated View of Ethics, Morality, and the Law

Although ethics as a branch of classical philosophy has been studied throughout the centuries, by and large these studies were left to the domains of philosophical and religious thinkers. More recently, because of the complexities of contemporary life and the heightened awareness of an educated public, ethical issues related to health care have surfaced as a major concern of both consumers and healthcare providers. It is now a widely held

belief that the patient has the right to know their medical diagnosis, the treatments available, and the expected outcomes. This information is necessary so that patients can make informed choices about their health and their care options with advice offered by health professionals.

Ethical principles that pertain to human rights are based on natural laws, which, in the absence of any other guidelines, are binding on human society. Inherent in these natural laws are, for example, the principles of respect for others, truth telling, honesty, and respect for life. Ethics as a discipline interprets these basic principles of behavior in broad terms that direct moral decision making in all realms of human activity, including health and health care (Guido, 2020; World Health Organization, 2017).

Although multiple perspectives on the rightness or wrongness of human acts exist, among the most commonly referenced are the writings of the 18th-century German philosopher Immanuel Kant, and those of the 19th-century English scholar and philosopher John Stuart Mill (Edward, 1967). Kant proposed that individual rights prevail and openly proclaimed the deontological notion of the “Golden Rule.” Deontology (from the Greek word *deon*, which means “duty,” and *logos*, which means “science” or “study”) is the ethical belief system that stresses the importance of doing one’s duty and following the rules. Thus, according to Kant, respect for individual rights is key, and one person should never be treated merely for the benefit or well-being of another person or group (Stanford Encyclopedia of Philosophy, 2016a). Mill, in contrast, proposed the teleological notion or utilitarian approach to ethical decision making that allows for the sacrifice of one or more individuals so that a group of people can benefit in some important way. He believed that given the alternatives, choices should be made that result in the greatest good for the greatest number of people (Stanford Encyclopedia of Philosophy, 2016b).

Likewise, the legal system and its laws are based on ethical and moral principles that, through experience and over time, society has accepted as behavioral norms (Guido, 2020; Tingle & Cribb, 2013). In fact, the terms *ethical*, *moral*, and *legal* are often used in synchrony. It should be made clear, however, that although these terms are certainly interrelated, they are not necessarily synonymous (Schiller et al., 2019; The Ethics Centre, 2016).

Ethics refers to the guiding principles of behavior, and **ethical** refers to norms or standards of behavior accepted by the society to which a person belongs. Although the terms *moral* and *morality* are generally used interchangeably with the terms *ethics* and *ethical*, nurses can differentiate between the notion of moral rights and duties and the notion of ethical rights and duties. **Moral values** refer to an internal belief system (what one believes to be right). This value system, defined as morality, is expressed externally through a person's behaviors. **Ethical dilemmas** are a "specific type of moral conflict in which two or more ethical principles apply but support mutually inconsistent courses of action" (Dwarswaard & van de Bovenkamp, 2015, pp. 1131–1132). An example that these authors provide is that the nurse must respect patient autonomy and individual patient responsibility when encouraging and supporting self-management behaviors, but the ethical principle of the patient's right to self-determination may clash with professional values that promote health and help achieve medical outcomes. **Legal rights and duties**, in contrast, refer to rules governing behavior or conduct that are enforceable by law under threat of punishment or penalty, such as a fine, imprisonment, or both.

The intricate relationship between ethics and the law explains why ethics terminology, such as *informed consent*, *confidentiality*, *nonmaleficence*, and *justice*, can be found within the language of the legal system (Guido, 2020). In keeping with this practice, nurses may cite professional commitment or moral obligation to justify the education of clients as one dimension

of their role. By law, the teaching role of nurses is legally mandated in the rules and standards of the nurse practice act and the state board of nursing that exist in the specific state where the nurse resides, is licensed, and is employed.

Practice acts are documents that define a profession, describe that profession's scope of practice, and provide guidelines for state professional boards regarding standards for practice, entry into a profession via licensure or certification, and disciplinary actions that can be taken when necessary. In the United States, all 50 states, the District of Columbia, and four U.S. territories have state boards of nursing that regulate individual nurse practice acts [NPAs] (Huynh & Haddad, 2020; Russell, 2012). However stringent, NPAs are constantly under review and are evolving to adapt to increasing standards. As of June 18, 2019, New York state requires registered nurses to acquire a bachelor's degree in nursing (BSN) within 10 years of licensure (New York State Education Department: Office of the Professions, 2018). This change in the NPA law was enacted based on research demonstrating improved outcomes for patients who are cared for by bachelor's prepared nurses (O'Brien et al., 2018). Practice acts were developed to protect the public from unqualified practitioners and to protect those with professional titles, such as registered nurse (RN), occupational therapist (OT), respiratory therapist (RT), and physical therapist (PT).

A model practice act (American Nurses Association, 1978) serves as a template for individual states to follow, with the goal being to minimize variability of professional practice from state to state within a profession. From the model, a state or other jurisdiction can develop its own practice act that addresses its specific needs in addition to including the basic information regarding scope of practice, licensure requirements, and so forth. Essentially then, a professional practice act is not only legally binding but also protected by the police authority of the state in the interest of protecting the public (Huynh & Haddad, 2020; Russell, 2012).

Evolution of Ethical and Legal Principles in Health Care

In the past, ethics was relegated almost exclusively to the philosophical and religious domains. Likewise, from a historical vantage point, medical and nursing care was considered a humanitarian, if not charitable, endeavor. Often it was provided by members of religious communities and others considered to be generous of spirit, caring in nature, courageous, dedicated, and self-sacrificing in their service to others. Public respect for doctors and nurses was so strong that for many years, healthcare organizations in which they worked were considered charitable institutions and, thus, were largely immune from legal action “because it would compel the charity to divert its funds for a purpose never intended” (Lesnik & Anderson, 1962, p. 211). In the same manner, healthcare practitioners of the past—who were primarily physicians and nurses—were usually regarded as Good Samaritans who acted in good faith and for the most part were exempt from lawsuits.

Although court records of lawsuits involving hospitals, physicians, and nurses can be found dating back to the early 1900s, their numbers pale in comparison with the volumes being generated daily in today’s world (Reising & Allen, 2007). Malpractice claims against nurses are on the rise, with over 90 million dollars paid in nursing malpractice claims between 2010 and 2015 (Brown, 2016). Further, despite the horror stories that have been handed down through the years regarding inhumane and often torturous treatment of prisoners, the mentally ill, the disabled, and the poor, in the past there was only limited focus on ethical aspects of that care. In turn, little thought was given to legal protection of the rights of people with such mental, physical, or socioeconomic challenges (Neil, 2015).

Clearly, this situation has changed dramatically. For example, informed consent—a

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

Over the years, legal authorities such as federal and state governments had maintained a hands-off posture when it came to issues of biomedical research or physician–patient relationships. However, the human atrocities committed by the Nazis in the name of biomedical research during World War II shocked the world into critical awareness of gross violations of human rights. Unfortunately, such abuses were not confined to wartime Europe. On U.S. soil, for example, the lack of treatment of African Americans with syphilis in Tuskegee, Alabama; the injection of live cancer cells into uninformed, nonconsenting older adults at the Brooklyn Chronic Disease Hospital; and the use of institutionalized children with intellectual disabilities to study hepatitis at the Willowbrook State School on Staten Island, New York, startled the nation and raised public awareness of disturbing breaches in the physician–patient relationship (Brent, 2001; Centers for Disease Control and Prevention, 2005; Rivera, 1972; Thomas & Quinn, 1991; Weisbard & Arras, 1984).

Stirred to action by these disturbing phenomena, in 1974 Congress moved with all due deliberation to create the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (U.S. Department of Health and Human Services [USDHHS], 1983). As an outcome of this unprecedented act, an institutional review board (IRB) for the protection of human subjects (IRBPHS) was required and rapidly established

at the local level by any hospital, academic medical center, agency, or organization where research on human subjects was being conducted. To this day, the primary function of these IRBs is to safeguard all human study subjects by insisting that research protocols include voluntary participation and withdrawal, confidentiality, truth telling, and informed consent, and that they address additional specific concerns for vulnerable populations such as infants, children, prisoners, and persons with mental illnesses. Every proposal for biomedical research that involves human subjects must be submitted to a local IRBPHS for intensive review and approval before the proposed study proceeds (USDHHS, 1983). Further, in response to concerns about the range of ethical issues associated with medical practice and a perceived need to regulate biomedical research, in 1978 Congress established the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (Brent, 2001; Thomas & Quinn, 1991; USDHHS, 1983).

But did the professions themselves speak up in the face of the outrageous violations of human rights in the name of research? Indeed, two professional groups acted well before the 1970s to establish uniform standards for professional education and conduct. The first was the American Medical Association (AMA), which wrote and published its Code of Medical Ethics in 1847. Summarized as the *Principles of Medical Ethics* in 1903, the code is currently in its sixth revision (AMA, 2016). All versions address the precedence of patients' welfare and physicians' moral rectitude over scientific accomplishment and professional gain. Despite such regular attention to the values to which physicians commit themselves individually and collectively, the preceding historical examples attest to a disconnection between espoused values and actual practice, which are indicative of past failures of professional accountability.

As early as 1950, the American Nurses Association (ANA) developed and adopted

an ethical code for professional practice, titled the *Code of Ethics for Nurses With Interpretative Statements*, that has since been revised and updated several times (ANA, 1976, 1985, 2001, 2015). This latest **code of ethics** represents an articulation of nine provisions for professional values and moral obligations with respect to the nurse–patient relationship and with respect to the profession and its mission. These provisions provide guidance to nurses in making ethical decisions throughout their practice (Gaines, 2020).

Although other health professions have adopted their own codes of ethics, the nursing profession's code has been recognized as exemplary and has been used as a template by other health discipline organizations in crafting their own ethics documents. Health professional organizations have accepted the responsibility for establishing standards of ethical behavior for members of their disciplines in the context of healthcare practice. In the end, however, it is up to the individual healthcare provider to take their professional ethics code to heart. The next section of this chapter addresses the application of ethical and legal principles and concepts by nurses to their clients.

In addition to these professional ethics codes, the American Hospital Association (AHA) created a document in 1973 titled *A Patient's Bill of Rights*, which was revised in 1992 (Association of American Physicians and Surgeons, 1995). Since then, a copy of these patient rights has been framed and posted in a public place in every healthcare facility across the United States. This document listed 12 expectations that patients should have about their health care, such as communication with the healthcare team, treatment, medical records, privacy, and confidentiality.

Further, federal standards developed by the Centers for Medicare and Medicaid Services (CMS)—an agency within the USDHHS—require that each patient be provided with a personal copy of these rights, either at the time of admission to the hospital or long-term care facility or prior to the initiation of care

or treatment at a surgery center, at a health maintenance organization (HMO), or when receiving home care or hospice services. In fact, many states have adopted the statement of patient rights for specific populations of health-care consumers as part of their state health code, which is why there is no one single version of this document but many versions to fit the needs of each facility (USDHHS, 2020).

Regardless of the version used, these patient rights fall under the jurisdiction of the law, rendering them legally enforceable by threat of penalty. In 2003, the AHA replaced its original patient's bill of rights with what became known as The Patient Care Partnership, which condensed these rights and responsibilities into six expectations written in multiple languages and easy-to-understand terms (AHA, 2008). In 2010 with the enactment of the Affordable Care Act, a new version of the patient's bill of rights was passed to provide dependents and people with preexisting conditions the right to be protected by health insurance (Bazemore, 2016).

Application of Ethical Principles to Patient Education

Various theories and traditions frame a health professional's understanding of the ethical dimensions in the healthcare setting (Butts & Rich, 2020; Lee & McTeigue, 2019). In considering the ethical and legal responsibilities inherent in the process of patient education, nurses and nursing students can turn to a framework of six major ethical principles—including the so-called “big four” principles initially proposed by Beauchamp and Childress (1977)—that are specified in the ANA's *Code of Ethics* (2015) and in similar ethics and patient rights documents promulgated by other healthcare organizations as well as the federal government. These principles, which encompass the very issues that precipitated

federal intervention into healthcare affairs, are autonomy, veracity, confidentiality, nonmaleficence, beneficence, and justice.

Autonomy

The term **autonomy** is derived from the Greek words *auto* (“self”) and *nomos* (“law”) and refers to the right of self-determination (Butts & Rich, 2020; Gaines, 2020; Guido, 2020). Laws have been enacted to protect the patient's right to make choices independently. Federal mandates, such as those dealing with informed consent, must be evident in every application for federal funding to support biomedical research. The local IRBPHS assumes the role of judge and jury to ascertain adherence to this enforceable regulation (Guido, 2020; Gupta, 2013).

The Patient Self-Determination Act (PSDA), which was passed by Congress in 1991 (Ulrich, 1999), is a clear example of the principle of autonomy enacted into law. Any healthcare facility that receives Medicare and/or Medicaid funds must comply with the PSDA. This law requires that, either at the time of hospital admission or prior to the initiation of care or treatment in a community health setting,

every individual receiving health care be informed in writing of the right under state law to make decisions about his or her health care, including the right to refuse medical and surgical care and the right to initiate advance directives. (Mezey et al., 1994, p. 30)

Although ultimate responsibility for discussing treatment options and a plan of care as well as obtaining informed consent rests with the physician, Menendez (2013) and The Joint Commission (2016) point out that it is the nurse's responsibility to ensure informed decision making by patients. This includes, but is certainly not limited to, witnessing the signing of an informed consent form after

verifying that the patient understands the procedure for which they are giving permission, and other advance directives (e.g., living wills, durable power of attorney for health care, and designation of a healthcare agent). Evidence of such instruction must appear in the patient's record, which is the legal document validating that informed consent took place (Hall et al., 2012; Shah et al., 2020).

One principle worth noting in the ANA's *Code of Ethics* addresses collaboration "with other health professionals and the public to protect human rights, promote health diplomacy, and reduce health disparities" (Gaines, 2020, p. 3). This principle certainly provides a justification for patient education both within and outside the healthcare organization. It provides an ethical rationale for health education classes open to the community, such as childbirth education courses, smoking cessation classes, weight reduction sessions, discussions of women's health issues, and positive interventions for preventing child abuse. Although health education per se is not an interpretive part of the principle of autonomy, it certainly lends credence to the ethical notion of assisting the public to attain greater autonomy when it comes to matters of health promotion and high-level wellness. In fact, consistent with the Model Nurse Practice Act (ANA, 1978), all contemporary nurse practice acts contain some type of direct or implicit statements identifying health education as a legal duty and responsibility of the registered nurse.

Another example of autonomy is the development and use of patient decision aid interventions that are designed to assist patients in making informed treatment choices (Bekker, 2010; Clifford et al., 2017). These patient **decision aids**, which include printed materials, videos, and interactive web-based tutorials, provide patients with information about specific health issues, diagnoses, treatment risks and benefits, and questionnaires to determine whether they need more information (Ankolekar et al., 2018). "The emphasis on

collaboration between providers and patients on decision making has, in turn, stimulated the development of tools to help patients and their families participate in clinical discussions and reach decisions that incorporate personal values and goals" (Wittmann-Price & Fisher, 2009, p. 60). A shared decision-making (SDM) paradigm has emerged that takes into consideration the input from both the patient and the provider so that there is two-way information sharing, consideration is based on patient preferences, and both parties are involved in the final decision-making process about treatment options (Ankolekar et al., 2018).

Veracity

Veracity, or truth telling, is closely linked to informed decision making and informed consent. The landmark decision by Justice Benjamin Cardozo (*Schloendorff v. Society of New York Hospitals*, 1914) identified an individual's fundamental right to make decisions about their own body. This ruling provides a basis in law for patient education or instruction regarding invasive medical procedures. However, nurses are often confronted with other issues of truth telling in the interest of full disclosure of information with their patients. For example, a nurse might want to suggest alternative treatments with a patient yet learns that the physician did not disclose all possible treatment options when prescribing a medical regimen for the care of this patient (Rankin & Stallings, 1990). Thus, in some instances, nurses may find themselves in an ethical bind, because nursing actions must be consistent with medical therapies prescribed by physicians. If such a dilemma arises, the nurse has a variety of actions available. One possibility would be to inform the physician of the professional double jeopardy and engage with them in achieving a course of action that best meets the patient's medical needs while respecting the patient's autonomy. The second possibility is to seek out the institutional ethics committee or an ethics consultant for assistance in

negotiating interactions with both the physician and the patient (Bonsall, 2015; Menendez, 2013; Robichaux, 2012). An institutional ethics committee also could be helpful in resolving ethical conflicts that arise with differences between professional values and the values of the organization in which nurses and physicians work (Gaudine et al., 2011).

Cisar and Bell (1995) offer the following explanation of the four elements making up the notion of informed consent that are such vital aspects of patient education and that are still pertinent today:

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

Although all four of these elements might be satisfied, the patient may still choose to reject the regimen of care suggested by health-care providers. This decision could be based on the cost of a treatment, or it might reflect certain personal or religious beliefs. Whatever the underlying motivation, it must be recognized by all concerned that competent,

informed patients cannot be forced to accept treatment if they are aware of the alternatives as well as the consequences of any decision (Bonsall, 2015; Cisar & Bell, 1995; Menendez, 2013).

Another dimension of the legality of truth telling relates to the role of the nurse as expert witness. Professional nurses who are recognized for their skill or expertise in a specific area of nursing practice may be called on to testify in court on behalf of either the plaintiff (the one who initiates the litigation) or the defendant (the one being sued). The role of nurse as an expert witness, on either side, is to assess the care delivered in the case and offer an opinion on whether or not the care met the level of care accepted as standard (Casey, 2020).

In contemporary biomedical ethics, Zolkefli (2018) examines the value in health-care settings of truth telling, a highly regarded quality of health professionals. Truth telling ensures patient autonomy, patient empowerment, and the ability of patients to make informed decisions for the benefit of their overall health. However, this author raises important issues about giving too much truthful information, which may be overwhelming and unduly stressful for some patients and may take away hope that is an essential psychological need of patients to carry on with their life.

Confidentiality

Confidentiality refers to personal information that is entrusted and protected as privileged information via a social contract, healthcare standard or code, or legal covenant. When this information is acquired in a professional capacity from a patient, healthcare providers may not disclose it without consent of that patient. If sensitive information were to be unprotected, patients would lose trust in their providers and would be reluctant to openly share problems with them or even seek medical care at all (Butts & Rich, 2020; Lee & McTeigue, 2019; University of California, Irvine, 2015).

A distinction must be made between the terms *anonymous* and *confidential*. Information is anonymous when, for example, researchers are unable to link any subject's identity in the medical record of that person. Information is confidential when identifying materials appear on subjects' records but can be accessed only by the researchers (Statistics Solutions, 2018; Tong, 2007).

Only under special circumstances may confidentiality be ethically broken, such as when a patient has been the victim or subject of a crime to which the nurse or doctor is a witness (Lesnik & Anderson, 1962; Merideth, 2007; Wills, 2017; Wood, 2020). Other exceptions to confidentiality occur when nurses or other health professionals suspect or are aware of child or elder abuse, narcotic use, legally reportable communicable diseases, gunshot or knife wounds, or the threat of violence toward someone. To protect others from bodily harm, health professionals are legally permitted to breach confidentiality (Wills, 2017; Wood, 2020).

In the case of communicable diseases, patients should not be forced or coerced to name their contacts, again because respecting confidentiality maintains trust between the patient and the nurse or other health providers. But is it fair to deprive a vulnerable spouse or other contact of this important health information? Is it morally acceptable to put one person's rights above those of another or of a community of people? In some situations, yes, although these decisions are best considered after much deliberation with the patient and other health professionals. Of course, if a patient discloses the identity of their contacts, health professionals are mandated to inform them in accordance with applicable state laws. If a patient tests positive for HIV/AIDS, for example, and has no intention of telling their spouse about this diagnosis, the physician has an obligation to warn the spouse directly or indirectly (i.e., through anonymous lab reporting) of the risk of potential harm (Tong, 2007; Wood, 2020).

The principle of confidentiality with respect to infectious diseases has been put to the test with the recent occurrence of the COVID-19 pandemic. The need for contact tracing is essential to slow the spread of COVID-19 through such public health measures as letting people know they have been exposed, monitoring their health for signs and symptoms, helping people get tested, and asking people to self-isolate if infected or self-quarantine if they are a close contact. According to the CDC (2021), "all aspects of case investigation and contact tracing must be voluntary, confidential, and culturally appropriate... [and] efforts to locate and communicate with clients and close contacts must be carried out in a manner that preserves confidentiality and privacy of all involved" (paras. 1–2). That means that the name of the client (the person infected with the virus) cannot be revealed unless permission is granted, and confidential information gathered cannot be given to third parties, such as roommates, neighbors, and family members. Likewise, any information about the contacts (those exposed) also remains confidential (CDC, 2021).

As for people who have activated COVID-19 exposure notifications on their smartphones or downloaded other mobile apps, these systems do not track user locations. Therefore, such technology is both voluntary and anonymous and, thus, individual privacy is protected. However, health department officials are hampered in efforts to protect the public because they are not privy to user data—so they do not know where exposures happened, they cannot follow up to determine if exposed people are self-isolating and testing, and they are unable to identify potential hot spots for infection. Thus, the guarantee of individual privacy has limited the utility and effectiveness of digital contact tracing. In addition, equity is a concern because a person must own a smartphone or other mobile device to use the apps, which leaves some people vulnerable without access to this type of digital service (Van Ness, 2021).

Adequate deliberation with the patient and others can reveal circumstances in which the reality is even more complex. For example, if the physician or other primary healthcare provider explores the patient's rationale for not wanting to inform their spouse of the infectious disease status, it may be out of fear of inciting domestic violence. According to Brent (2001), "this area of legislation concerned with health care privacy and disclosure reveals the tension between what is good for the individual vis-à-vis what is good for society" (p. 141).

The 2013 updated Health Insurance Portability and Accountability Act (HIPAA) ensures nearly absolute confidentiality related to dissemination of patients' information, unless the patients themselves authorize release of such information. One goal of the HIPAA policy, first enacted by Congress in 1996, is to limit disclosure of patient healthcare information to third parties, such as insurance companies or employers. This law, which requires patients' prior written consent for release of their health information, was never meant to interfere with consultation between professionals but is intended to prevent, for example, "elevator conversations" about private matters of individuals entrusted to the care of health professionals. In a technologically advanced society with electronic medical records and data transactions between providers such as exists in the United States today, this law is a must to ensure confidentiality (Edemekong et al., 2020). Currently, in some states and under certain conditions, such as death or impending death, a spouse or members of the immediate family can be apprised of the patient's condition if this information was previously unknown to them. Despite federal and state legislation protecting the confidentiality rights of individuals, there are legal exceptions that allow health professionals to breach confidentially without the patient's permission. For example, health providers have a moral and ethical obligation to divulge to others that they may be at risk of contracting an infectious, communicable disease (e.g., HIV/AIDS

or COVID) due to contact with an infected person (Edemekong et al., 2020).

Nonmaleficence

Nonmaleficence is defined as "do no harm" and refers to the ethics of legal determinations involving negligence and/or malpractice (Beauchamp & Childress, 2012; Payne, 2017). According to Brent (2001), **negligence** is defined as "conduct which falls below the standard established by law for the protection of others against unreasonable risk of harm" (p. 54). The author further asserts that the concept of professional negligence "involves the conduct of professionals (e.g., nurses, physicians, dentists, and lawyers) that falls below a professional standard of due care" (p. 55). As clarified by Tong (2007), due care is "the kind of care healthcare professionals give patients when they treat them attentively and vigilantly so as to avoid mistakes" (p. 25). For negligence to exist, there must be a duty between the injured party and the person whose actions (or nonactions) caused the injury. A breach of that duty must have occurred, it must have been the immediate cause of the injury, and the injured party must have experienced damages from the injury (Brent, 2001).

The term **malpractice**, by comparison, still holds as defined by Lesnik and Anderson in 1962. Malpractice, these authors assert, "refers to a limited class of negligent activities committed within the scope of performance by those pursuing a particular profession involving highly skilled and technical services" (p. 234). More recently, malpractice has been specifically defined as "negligence, misconduct, or breach of duty by a professional person that results in injury or damage to a patient" (Reising & Allen, 2007, p. 39). Thus, malpractice is limited in scope to those whose life work requires special education and training as dictated by specific educational standards. In contrast, negligence refers to all improper and wrongful conduct by anyone arising out of any activity.

Reising and Allen (2007) describe the most common causes for malpractice claims specifically against nurses, but these causes are also relevant to the conduct of other health professionals within the scope of their practice responsibilities:

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

The concept of *duty* is closely tied to the concepts of negligence and malpractice. Nurses' duties are spelled out in job descriptions at their places of employment. Policy and procedure manuals of healthcare facilities are certainly intended to protect the patient and ensure good-quality care, but they also exist to protect both the employee—in this instance, the nurse—and the employer against litigation. Policies are more than guidelines. Policies and procedures determine standards of behavior (duties) expected of employees of an institution and can be used in a court of law in the determination of negligence or malpractice (Lee & McTeigue, 2019; Morales, 2012; Reising, 2012; Weld & Bibb, 2009; Yoder-Wise, 2018).

The role of the registered nurse has evolved over the past few decades. Nurses' responsibilities now include monitoring complex equipment and data, operating lifesaving equipment, coordinating patient care and services, and administering million-dollar healthcare programs (Weld & Bibb, 2009). As a result, nurses now have a higher duty of care to their patients, which in return can result in more risk of claims against them for negligence or malpractice. Expectations of professional nursing performance also are measured against the nurse's level of education and concomitant skills, standing orders issued by the physician, institution-specific

protocols, standards of care upheld by the profession (ANA), and standards of care adhered to by any subspecialty organizations of which the nurse may be a member. If, for example, a nurse is certified in a clinical specialty or is identified as a "specialist" although not certified as such, they will be held to the standards of that specialty (Yoder-Wise, 2018).

In the instance of litigation, the key operational principle is that the nurse is not measured against the optimal or maximum professional standards of performance; rather, the yardstick consists of the prevailing practice of what a prudent and reasonable nurse would do under the same circumstances in a similar community (Morales, 2012). Thus, the nurse's duty to perform patient education (or lack thereof) is measured against not only the prevailing policy of the employing institution but also the prevailing practice in the community. For example, in the case of clinical nurse specialists (CNSs), nurse practitioners (NPs), and clinical education specialists (CESs), the practice is measured against institutional policies for this level of worker as well as against the prevailing practice of nurses performing at the same level in the community or in the same geographic region.

Beneficence

Beneficence is defined as "doing good" for the benefit of others. It is a concept that is legalized through properly carrying out critical tasks and duties contained in job descriptions; in policies, procedures, and protocols set forth by the healthcare facility; and in standards and codes of ethical behaviors established by professional nursing organizations (Beauchamp & Childress, 2012; Payne, 2017). Adherence to these various professional performance criteria and principles, including adequate and current patient education, speaks to the nurse's commitment to act in the best interest of the patient. Such behavior emphasizes patient welfare but not necessarily to the harm of the healthcare provider.

The effort to save lives and relieve human suffering is a duty to do what is right only within reasonable limits. For example, when COVID-19 first appeared, the means to diagnose and treat this potentially fatal disease were unknown. Some health professionals protested that the duty of beneficence did not include caring for patients who put providers at risk for this disease due to the lack of appropriate personal protective equipment (PPE). Others maintained that part of the decision to become a health professional involves the acceptance of certain professional risks; it is part of the job (Milton, 2020). Beneficence determines when it becomes unethical to refuse to care for patients based on actual versus perceived risk to the healthcare professional.

Justice

Justice speaks to fairness and the equitable distribution of goods and services. The law is the justice system. The focus of the law is the protection of society; the focus of health law is the protection of the consumer. It is unjust to treat one person better or worse than another person in a similar condition or circumstance, unless a difference in treatment can be justified with good reason (Beauchamp & Childress, 2012). Justice is a complex ethical principle concerned with distributing benefits and burdens fairly to individuals in social institutions, but it opens the question of what it means to be fair (Feinsod & Wagner, 2008; Krau, 2015).

In today's healthcare climate, professionals must be as objective as possible in allocating scarce medical resources in a just manner. As an example, the question of distributed justice unexpectedly became a priority in the recent COVID-19 pandemic. Who should receive priority treatment against this life-threatening disease? Anticipating having to ration care due to a shortage of critical resources, such as a lack of supplies and equipment, adequate hospital beds, and the number of healthcare workers needed to treat the sick,

this ethical question was proactively grappled with during this crisis by managers of health facilities, healthcare providers, and public health officials throughout the United States as well as in many other countries around the world (Tobin-Tyler, 2020).

Decision making for the fair distribution of resources includes the following criteria as defined by Tong (2007):

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

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

As noted earlier, adherence to the rights of patients is legally enforced in most states. In turn, the nurse or any other health professional can be subjected to penalty or litigation for discrimination in provision of care. Regardless of their age, gender, physical disability, sexual orientation, or race, for example, the patient has a right to proper attention and treatment. Patients also have a right to proper instruction regarding risks and benefits of invasive medical procedures (Guido, 2020) and to adequate education for carrying out self-care activities, such as home dialysis, that are beyond normal activities of daily living for most people.

Furthermore, a nurse employed by a healthcare facility agrees to a binding contract, written or tacit, to provide nursing services in accordance with the policies of the facility. A nurse who fails to provide nursing

care (including educational services) based on patient diagnosis, or who persists in providing substandard care based on patient age, diagnosis, culture, national origin, sexual preference, and the like, can result in the nurse being held liable for breach of contract with the employing institution (Emanuel, 2000).

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

Nevertheless, uninsured and Medicare and Medicaid patients remain subject to other, more subtle discrimination. Because many outpatient facilities do not accept these patients, this restriction on their right of access to health care extends to their right to access health education. Emanuel (2000) raises a critical point in asserting that “the diffuseness of decision making in the American health care system precludes a coherent process for allocating health care resources” (p. 8). Emanuel further contends that managed care organizations have systematically pursued drastic cost reductions by restructuring delivery systems and investing in expensive and elaborate information systems. For example, HMOs have bought out physician practices and have become involved in numbers of related activities with no substantial evidence that a high quality of health care will be achieved at lower prices. Furthermore, efforts to contain health-care costs have pressured healthcare staff to do more with less. “Limited resources force tough choices in quality of care” (Dowd, 2018, p. 1).

These issues influence whether health educators can surmount the obstacles potentially

blocking the patient education process. In the interest of cutting costs, HMOs also have succeeded in shortening lengths of hospital stays. This development, in turn, has had a tremendous effect on the delivery of education to the hospitalized patient and presents serious obstacles to the implementation of this mandate. Lack of time serves as a major barrier to the nurse’s or other health professional’s ability to give discharge instructions that contain sufficient information for self-care. Also, low health literacy, age, cultural influences, and illness acuity level interfere with the patient’s ability to process the information necessary to meet their physical and emotional needs (Marks, 2009).

Clearly, professional nurses are mandated by organizational policy as well as by federal and state regulations to provide patient education. Great care must be taken to ensure that the education justly due to the patient will be addressed post discharge, either in the ambulatory care setting, at home, or in the physician’s office.

The Ethics of Education in Classroom and Practice Settings

The Student-Teacher Relationship

Many of the foundational principles and concepts of ethics that apply to patient care also apply to questions of what ought to be done or how health professionals ought to behave in the education of students for the health professions. Students and teachers have their own perspectives, visions, values, and preferences that are unknown to each other. These two worldviews come together in the classroom and clinical settings. They must be negotiated and understood by each party so connections can be formed for the process of education to proceed with trust and respect (Freedman, 2003; Gillespie, 2002).

A balance of power exists between the teacher (expert) and the student (novice). “An effective student–educator relationship is a key factor to ensure a positive learning climate where learning can take place...” (Froneman et al., 2016, p. 1595). The teacher possesses discipline-specific expertise that is key to the student’s academic success, career achievement, and competent care of patients. Students must be able to trust their teachers—even instantaneously—and believe that the instruction provided by them will be accurate, appropriate, and up to date. Students have a right to assume their instructors are competent, will employ that competence in the best interests of the students, will serve as mentors, and will be role models of professional nursing practice (Gillespie, 2002).

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

An exhaustive search of the nursing literature reveals scant information about the blurring of ethical boundaries in student–teacher

relationships. However, the medical profession has addressed this issue in academic medicine in a number of key articles. The examples, findings, and conclusions can be translated to pertain to the relationships between nursing students and nursing educators in academic and clinical settings. Nurse educators and clinical nursing faculty can use the following five specific criteria to distinguish between interactions that are appropriate in the context of the educational process and those that are less appropriate or even frankly inappropriate (Larkin & Mello, 2010; Martinez, 2000; Plaut, 1993; Plaut & Baker, 2011):

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

These five criteria can assist teachers in being fully honest with themselves regarding the appropriateness of counseling the student and can serve as an extremely useful guide in uncertain situations.

Students are autonomous agents. If they choose to follow the prescribed course of study and are successful, they will develop professional autonomy, attain their professional goals, achieve professional competence, and be equipped to develop relationships with colleagues and patients. Students are responsible for speaking up when they experience problems with or obstacles to their learning. Otherwise, their teachers may make overly ambitious demands on and have unrealistic expectations for students in the learning process. Just as students have the right to expect honesty from their teachers, so do they have a reciprocal duty to be truthful—such as when they have not done an assignment or prepared for a class activity or have made a mistake. In addition, truthfulness affects a vulnerable third party: the patient whose care is at the

hands of the student. Taking responsibility for one's missteps as a student reveals the student's commitment to honesty, the primacy of patient welfare, and trustworthiness (Reiser, 1994).

Student autonomy becomes an extremely important point in academic settings when parents of students try to become involved in educational decisions. The Family Educational Rights and Privacy Act (FERPA) of 1974 was created to protect student education records (U.S. Department of Education [USDOE], 2018). When the student is under the age of 18, the right to access records belong to the parent, but once the student turns 18 years of age or attends school beyond the high school level, these rights transfer directly to the student. In many cases, this becomes an area of conflict when students begin college and do not provide a waiver for their parents to receive educational records, even though their parents may be the ones paying for their education (USDOE, 2011).

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

of their jobs if they are hearing a censored rendition of those concerns?

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

In addition, consider the ethical import of the transience of many student–teacher relationships (Christakis & Feudtner, 1997). For example, the system of nursing education can create communities of relative strangers. A nursing student may conflate trust with authority when a visiting professor teaches a core course in the curriculum. Although the visiting professor may be a renowned authority on complementary and alternative therapies, she may be authoritarian in the classroom, a poor exemplar of putting the student's educational needs first. The student may deferentially endure the class, knowing that sooner or later it will end and the professor will return to her home institution. Such a poor learning climate discourages any reciprocity of concern or trust, impedes the student's professional development, and deprives the professor of valuable opportunities to demonstrate humility before the students.

Students rely on their teachers to be role models and mentors. They observe how teachers hold themselves and other instructors accountable to honest and conscientious practice standards. They witness how teachers treat students and colleagues. Such teacher behaviors exemplify instruction in a relational context: Technical information is interwoven with role modeling. From these observations, students receive lessons that assist them in developing and establishing habits of interaction with coworkers, patients, and, if they become educators themselves, their own future students (Larkin & Mello, 2010; Plaut & Baker 2011; Reiser, 1993).

The Patient–Provider Relationship

Nurses as well as other healthcare providers and the patients they care for also have their own worldviews that come together in the practice setting. These perspectives must be negotiated and understood by each party for the process of patient education to occur with a sense of trust.

As with the student–teacher relationship, it is important to recognize the balance of power that exists between a nurse—even a nursing student—and a patient. The nurse possesses medical expertise: keys to the patient’s health, well-being, and ability to work, play, go to school, or engage in social relationships. For those reasons, the ethics of being a patient typically includes respecting nurses and other healthcare providers and trusting them to have the patient’s best interests at heart (Aravind et al., 2012; Hanna & Suplee, 2012; National Council of State Boards of Nursing [NCSBN], 2018). Lachman (2012) speaks to the care nurses render to patients as being an ethical task, and Raina et al. (2014) and Ludwig and Burke (2013) address the ethical perspectives of the physician–patient relationship. Caring is not only essential for the physical and psychological well-being of patients but caring also requires getting involved in a network of relationships to meet the patient’s needs. Patients have a moral claim on the nurse’s and physician’s competence and on the use of that competence for the patient’s welfare (Pellegrino, 1993; Redman, 2008).

The blurring of professional–personal boundaries is also an area of ethical importance common to health providers’ and health provider students’ relationships with their patients. The potential for blurred boundaries between professionals and patients is particularly evident because of the intimacies of the practice setting. Patient care and patient education can take place when patients are wearing little clothing, are lying down in a bed, are sharing personal information with their provider, or

are in the context of medically related physical contact. Again, the five specific criteria noted earlier in the student–teacher relationship section are relevant here. Simply substitute the word *patient* or *patient–provider relationship* in place of the word *student* or *student–teacher relationship* (used in the original criteria) to distinguish between interactions that are appropriate in the context of the practice setting and those that are less appropriate or even frankly inappropriate (Hanna & Suplee, 2012; Larkin & Mello, 2010; Martinez, 2000; NCSBN, 2018; Plaut, 1993; Plaut & Baker, 2011):

- Risk of harm to the patient or to the patient–provider relationship
- Presence of coercion or exploitation
- Potential benefit to the patient or to the patient–provider relationship
- Balance of the patient’s interests and the provider’s interests
- Presence of professional ideals

These five criteria can assist nurses and other providers in being fully honest with themselves regarding the appropriateness of providing care to patients, including teaching and counseling them, and can serve as an extremely useful guide in uncertain situations.

Nurses and other health professionals are obligated to remain mindful of the power imbalance between themselves and their patients, to put the patient’s welfare before their own concerns, and to reflect honestly on the consequences of blurred boundaries to the patient and to their relationship with the patient in the practice setting.

Out of a respect for patient autonomy, models of medical decision making shared between health professionals and patients has assumed primacy in various health communication curricula and practices (deBocanegra & Gany, 2004; Donetto, 2010; Freedman, 2003). As mentioned previously, decision aids have been developed to enhance collaboration between patients and providers in making informed decisions (Ankoleker et al., 2018;

Clifford et al., 2017). Health-related information is given to patients so they have the opportunity to make their choices and preferences known to professional caregivers. Likewise, the shared decision making (SDM) paradigm allows for a bidirectional approach whereby both the patient and the provider weigh in on potential treatment options. Health professionals' perceptions of SDM highlight both barriers and facilitators to implementing this type of model (Légaré et al., 2008). Nevertheless, this contemporary model preserves the patient's right to autonomy in making choices affecting their own body and results in a much-improved process of ethical decision making for the benefit of the patient.

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

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

Furthermore, some patients believe that they should behave like good patients by taking all medications or doing all exercises as prescribed, adhering to a recommended diet, not complaining, and so forth, so that their health professional will like them, consider

them worthy of their time, and want to continue to take care of them (Buckwalter, 2007; Freedman, 2003). This desire to be a good patient underscores how dependent and vulnerable patients can feel. Even when presenting for a screening mammogram or follow-up MRI or CT scan, patients are not at their best. At every medical encounter, there exists the potential for discovering something that merits concern.

In the practice setting, it is plausible that a nurse providing discharge instructions to a patient might not necessarily give the patient a fair share of their time or be open to all the patient's questions if the nurse knows they will never see that patient again. Admittedly, the better the patient education, the longer the patient will likely remain out of the hospital. However, if the nurse is extremely busy with other competing priorities or is tired from having worked two shifts in a row, they may not reflect on how fatigue or work demands lead to a failure to focus primarily on this patient's welfare. It may be easier for the nurse to assume a let-someone-else-deal-with-it attitude. Transient relationships facilitate a lack of focus on the welfare, time, and interests of each patient.

All professional nurses will face a conflict of values, ethically and professionally, at some point in their career (Robichaux, 2012). Ethical dilemmas happen when ethics principles can be interpreted from different perspectives. That is, what is right or wrong can be debated and different courses of action are recommended by one or more parties. So, too, some actions can have two outcomes, one of which is beneficial and the other harmful. In ethics, this is known as the doctrine of double effect. For example, withdrawing life support relieves suffering but may result in someone's demise; administering high doses of opioids to a terminally ill patient may relieve pain and dyspnea but likely hastens death (Case Di Leonardi, 2012a). With respect to ethical leadership, nursing leaders need to be able to anticipate ethical challenges and focus on appropriate

professional values. Key to ethical nurse leadership is a willingness to collaborate with colleagues, apply evidence-based practice to remain competent, involve patients in their own care, and invite feedback from patients and other professionals for sound ethical decision making to occur (Gallagher & Tschudin, 2010; Ho & Pinney, 2015).

Legality of Patient Education and Information

The patient's right to adequate information regarding their physical condition, medications, risks, and access to information regarding alternative treatments is specifically spelled out in the revised edition of *A Patient's Bill of Rights* (AHA, 1992; President's Advisory Commission, 1998). In the United States, patient rights are based on both ethical and legal standards that not only create uniformity of care across healthcare settings but also provide patients with assurance of uniform standards of expected treatment regardless of their social, economic, religious, gender, or ethnic status. Countries other than the United States do have laws to protect a variety of individual rights, but not all have a specific patient bill of rights protecting human rights related specifically to health care (Olejarczyk & Young, 2020).

As noted earlier, many American states have adopted patient rights as part of their health code, thus rendering them legal and enforceable by law. Patients' rights to education and information also are regulated through standards put forth by accrediting bodies such as The Joint Commission [TJC] (2015), formerly known as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Although these standards are not enforceable in the same manner as law, lack of organizational conformity can lead to loss of accreditation, which in turn jeopardizes the facility's eligibility for third-party

reimbursement, as well as loss of Medicare and Medicaid reimbursement. Lack of organizational conformity also can lead to loss of public confidence in the institution.

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

It should be noted that the AHA's 1975 original draft rendition of *A Patient's Bill of Rights*, along with all the later revisions of these rights, is linked to or associated with every ethical principle. The revised *A Patient's Bill of Rights* (AHA, 1992) is rooted in the conditions of participation in Medicare set forth under federal standards established by the CMS. Corresponding accreditation standards promulgated by TJC further emphasize these standards. All these laws and professional standards serve to ensure the fundamental rights of every person as a consumer of healthcare services. **Table 2-1** outlines the relationship of ethical principles to the laws and professional standards applicable to each principle.

Physicians are responsible and accountable for proper patient education. Realistically, however, the nurse or some other physician-appointed designee often carries out patient education. Physicians' responsibility notwithstanding, "patient education is central to the culture of nursing as well as to its legal practice" (Redman, 2008, p. 817) by virtue of respective state nurse practice acts. The issue regarding patient education is not necessarily one of omission on anyone's part. Rather, the heart of the matter may be proper documentation that teaching has, in fact, been done.

Table 2-1 Linkages Between Ethical Principles, the Law, and Practice Standards

Ethical Principles	Legal Actions/Decisions and Standards of Practice
Autonomy (self-determination)	Cardozo decision regarding informed consent Institutional review boards Patient Self-Determination Act <i>A Patient's Bill of Rights</i> TJC standards CMS standards
Veracity (truth telling)	Cardozo decision regarding informed consent <i>A Patient's Bill of Rights</i> Nursing Practice Acts and Code of Ethics for Nurses TJC standards CMS standards
Confidentiality (privileged information)	Privileged information <i>A Patient's Bill of Rights</i> TJC standards CMS standards HIPAA
Nonmaleficence (do no harm)	Malpractice/negligence rights and duties Nurse Practice Acts and Code of Ethics for Nurses <i>A Patient's Bill of Rights</i> <i>Darling v. Charleston Memorial Hospital</i> State health codes TJC standards CMS standards
Beneficence (doing good)	<i>A Patient's Bill of Rights</i> State health codes Job descriptions Nurse Practice Acts and Code of Ethics for Nurses Institutional policy and procedure manuals TJC standards CMS standards
Justice (equal distribution of benefits and burdens)	<i>A Patient's Bill of Rights</i> Antidiscrimination/affirmative action laws Americans with Disabilities Act TJC standards CMS standards

Legal and Financial Implications of Documentation

The 89th Congress enacted the Comprehensive Health Planning Act in 1965, Public Law 89-97, 1965 (Boyd et al., 1998). The

entitlements of Medicare and Medicaid—which revolutionized the provision of health care for older adults and people who are socioeconomically deprived—were established through this act. The act stressed the importance of disease prevention and rehabilitation in health care. Thus, to qualify for Medicare and Medicaid reimbursement, “a hospital has

to show evidence that patient education has been a part of patient care” (Boyd et al., 1998, p. 26). Proper documentation provides written testimony that patient education has indeed occurred.

For at least the past 25 years, TJC has reinforced the federal mandate by requiring documentation of patient and/or family education in the patient record. Pertinent to this point is the doctrine of **respondeat superior**, or the master–servant rule. Respondeat superior provides that the employer may be held liable for negligence, assault and battery, false imprisonment, slander, libel, or any other tort committed by an employee (Lesnik & Anderson, 1962). The landmark case supporting the doctrine of respondeat superior in the healthcare field was the 1965 case of *Darling v. Charleston Memorial Hospital*. Although the *Darling* case dealt with negligence in the performance of professional duties of the physician, it brought out—possibly for the first time—the professional obligations or duties of nurses to ensure the well-being of the patient (Brown, 1976).

In any litigation where the doctrine of respondeat superior is applied, outcomes can hold the organization liable for damages (monetary retribution). Thus, it is the responsibility of the nurse as both employee and professional providing patient education to appropriately document that education and to be critically conscious of the legal and financial ramifications to the healthcare facility in which they are employed (ANA, 2010; Marcus, 2014).

Casey (1995) pointed out many years ago that of all lapses in documentation, patient teaching was identified as “probably the most undocumented skilled service because nurses do not recognize the scope and depth of the teaching they do” (p. 257). Lack of documentation continues to reflect negligence in adhering to the mandates of the nurse practice acts. This laxity is unfortunate because patient records can be subpoenaed for court evidence in malpractice cases. Appropriate documentation can be the determining factor in the outcome

of litigation (Case Di Leonardi, 2012b). Pure and simple, if the instruction isn’t documented, it didn’t occur!

Furthermore, documentation is a vehicle of communication that provides critical information between other health professionals involved with the patient’s care. Given that patient education is a multidisciplinary responsibility, a recent research study found that documentation varies among providers (Shipman et al., 2016). Failure to document not only renders other staff potentially liable but also renders the facility liable and in jeopardy of losing its accreditation. Concomitantly, the institution is also in danger of losing its appropriations for Medicare and Medicaid reimbursement (Leventhal, 2014).

In this digital age, implementation of an electronic medical records (EMR) system, also known as electronic health records (EHR) system, is widespread in all healthcare settings with the passage of the Health Information Technology for Economic and Clinical Health Act (HITECH), which was part of the American Recovery and Reinvestment Act of 2009 (Blumenthal & Tavenner, 2010). Thorough and accurate documentation has always been of utmost importance in the delivery of safe, high-quality care, and it applies equally to paper and digital records (Balestra, 2017; Bernat, 2013; Palabindala et al., 2016). It has been estimated that 35% to 40% of malpractice cases are lost because of poor documentation (Zamboni, 2016).

Although the EMR/EHR system promises many benefits, it also has potentially “serious unintended consequences” (Bowman, 2013, p. 1). Its advantages, for example, are that typed notes are much easier to read, prompts remind providers to deliver medications and care on time, information can be rapidly retrieved for team-based care coordination, confidentiality of patient information is more protected, information is provided for third-party billing, and, in the long run, healthcare costs are expected to decrease. However, digital recording also has its disadvantages, such as drop-down

menus that do not allow for as much detail as handwritten notes; if no new information has surfaced, it is easy to be tempted not to record anything; all it takes is the click of a mouse on a wrong choice in the electronic system to lead to the wrong medication being prescribed; and digital entries are not as robust as personal handwritten entries to trigger a clear memory of events in the provider.

Poor documentation, regardless of whether it be paper or digital recordings, carries the same weight in the court of law (Gamble, 2012; Hoyt, 2014; Zamboni, 2016). With the relatively recent adoption and use of EHRs, legal and ethical dilemmas as well as financial questions remain with respect to the extent to which digital records can reform health care (Gamble, 2012; Sittig & Singh, 2011; Zamboni, 2016). Information integrity—that is, data being lost or incorrectly entered, displayed, and transmitted (known as e-iatrogenesis), and reduced provider–patient focus—that is, the consumer perceiving the nurse is not listening or making sufficient eye contact because of attention being given instead to navigating the screens and making entries—are still serious issues that need to be resolved (Bowman, 2013; Hoyt, 2014; Zamboni, 2016).

Even in today's current practice environment, an invaluable interdisciplinary method proposed by Snyder (1996) to document patient education is still pertinent. This method relies on a flow sheet that used to be included in the patient's paper chart but now can be incorporated into electronic medical records. The flow sheet includes identification of patient and family educational needs based on the following important variables:

- Readiness to learn (based on admission assessment of the patient)
- Obstacles to learning, which might include language, sensory deficits such as lack of vision or hearing, low literacy, cognitive deficits, or other challenges
- Referrals, which might include a patient advocate or an ethics committee

The form also provides documentation space for who was taught (e.g., patient or family), what was taught (e.g., medication administration), when it was taught, which strategies of teaching were used (teaching methods and instructional materials), and how the patient responded to instruction (which outcomes were achieved).

Informed consent has become the primary standard of protecting patients' rights and assists in guiding ethical and legal health-care practice. Although nurses are not responsible for completing the process of informed consent, they do have the duty to verify and document that consent has been given. Consent must be granted by the patient or legal guardian before a patient undergoes a procedure. The nurse also acts as a resource to patients who may ask for clarification or information to be repeated in terms they can understand. Patient education for this reason also must be documented. Simplistically, informed consent is a patient's right to establish what should or should not be done to their body (Menendez, 2013).

Brenner et al. (2009) examined informed consent and proposed returning to an educational model to increase patients' sense of control and thereby improve healthcare outcomes, such as compliance, disease prevention, and health promotion. These authors state that the current process of informed consent has discouraged patients from taking an active part in making their own healthcare decisions, by turning this process into essentially one of signing a liability waiver. However, to return to an educational model, the consent forms must be reviewed and revised for comprehensibility and educational value.

First and foremost, health literacy plays a significant role in a patient's ability to actively and effectively take part in their care. For example, Eltorai et al. (2015) found that invasive procedure consent forms were written on average at the 15th-grade level, yet the average U.S. adult reads at the 8th-grade level. Therefore, these forms make comprehension

difficult if not impossible for many patients. See Chapter 7 for more information on tools to assess the literacy level of patients and the readability of materials, such as consent forms.

Second, the informed consent process must change the way physicians deliver information. Brenner et al. (2009) explain that patients may have the fantasy misconception that the physician is a “great healer,” which creates a false perception of the outcome. A positive perception is developed when the physician shows empathy toward patients, acknowledging their fears and concerns, and reassuring them that their fears and concerns are expected and respected. The physician must recognize that negative outcomes can develop, as with any procedure, but continued support of the patient, regardless of the outcomes, is a necessity.

Because patient education and patient engagement are critical elements to meaningful consent, healthcare providers must be sure that patients understand their consent options and the impact of their decisions in choosing to consent. In the electronic age, informed consent involves educating patients about the sharing of their health information via the electronic health information exchange (eHIE)—the way healthcare providers access and share patient health information with one another by way of their computers. Patient education must include full transparency about such factors as privacy and security regarding who has access to information, why information might be shared, and how information is protected so that patients can make informed consent decisions (HealthIT.gov, 2014).

Economic Factors in Healthcare Education: Justice and Duty Revisited

Some might consider the parameters of healthcare economics and finances as objective information that can be used for any number of

purposes. Fiscal solvency and forecasting of economic growth of an organization are good examples of such purposes. Others would agree that in addition to the legal mandates for patient education and the importance of documentation, another ethical principle speaks to both quality of care and justice, which refers to the equitable distribution of goods and services. In the interest of patient care, the patient as a human being has a right to good-quality care regardless of their economic status, national origin, race, and the like. Furthermore, health professionals have a duty to ensure that such services are provided, and the healthcare organization has the right to expect that it will receive its fair share of reimbursable revenues for services rendered.

Thus, as an employee of a healthcare institution or agency, the nurse has a duty to carry out organizational policies and mandates by acting in an accountable and responsible manner. In an environment characterized by shrinking healthcare dollars, continuous shortages of staff, and dramatically shortened lengths of stay yielding rapid patient turnover, organizations are challenged to ensure that their professional staff are competent to provide educational services, while at the same time doing so in the most efficient and cost-effective manner possible. This is an interesting dilemma considering that patient education is identified as a legal responsibility of nurses in their state practice acts. Prelicensure education programs are challenged to prepare nursing students adequately for this critical function.

The principle of justice is a critical consideration in patient education. The rapid changes and trends in contemporary health care are, for the most part, economically driven. On the one hand, the managed care approach results in shrinking revenues. This trend, in turn, dictates shorter patient stays in hospitals and doing more with less. Consequently, health facilities are continuing to expand their clinical offerings into satellite types of ambulatory and home care services in an effort to increase

their revenues. At the same time, however, healthcare organizations are held to regulatory standards dictated by *A Patient's Bill of Rights*, to the regulations required to receive Medicare and Medicaid reimbursement, and to the eligibility standards to maintain agency accreditation (AHA, 1992). Described as chaotic by some, the U.S. healthcare system in many ways is challenged to maintain its humanistic and charitable origins that have characterized healthcare services in this country across the decades. Indeed, organizations that provide health care are caught between the need to allocate scarce resources and the necessity to provide just yet economically feasible services, including the regulated right and corresponding duty to provide health education to clients.

Financial Terminology

Given the fact that the role of the nurse as educator is an essential aspect of care delivery, this section provides an overview of financial terms that directly affects both staff and patient education. Such educational services are not provided without an accompanying cost of human and material resources. Thus, it is important to know that expenses are essentially classified into two categories: direct costs and indirect costs (Gift, 1994; Hughes, 2011 ; Spielman, 2020). The sources of revenue (profit) that an institution or agency can accumulate from patient education efforts are known as cost savings, cost benefit, and cost recovery (Abruzzese, 1992; Ghebrehiwet, 2005; Mitton & Donaldson, 2004).

Direct Costs and Indirect Costs

Direct costs are tangible, predictable expenses, a substantial portion of which include personnel salaries, employment benefits, and equipment (Spielman 2020; Gift, 1994; Hughes, 2011). This share of an organization's budget is almost always the largest percentage

of the total costs to operate any healthcare facility. Because of the labor-intensive function of nursing care delivery, the costs of nurses' salaries and benefits usually account for at least 50%—if not more— of the total facility budget. Of course, the higher the educational level of nursing staff, the higher the salaries and benefits, and, therefore, the higher the institution's total direct costs.

Time also is considered a direct cost, but it is often difficult to predict how long it will take nurses to plan, implement, and evaluate the individual patient teaching encounters and the educational programs being offered. If the time it takes to prepare and offer patient or staff education programs is greater than the financial gain to the institution, the facility may seek other ways of providing this service, such as computerized programmed instruction or a patient television channel.

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

Direct costs may be *fixed* or *variable*. **Fixed costs**, such as the salary of the nurse delivering a service or program, remain stable regardless of the volume (number of people) using that service or attending that program. **Variable costs**, such as supplies, change with an increase or decrease in the volume of services or programs delivered (Gift, 1994). Variable costs can become fixed costs when volume remains consistently high or low over time. From an educational perspective, the needs and demands for patient teaching depend in the number and diagnostic type of patients, such as the more costly intensive

one-to-one instruction versus the less expensive standardized group teaching sessions.

Indirect costs are those costs not directly related to the actual delivery of an educational program but are the result of services shared by other departments in the facility (Spielman 2020; Gift, 1994; Hughes, 2011). They include, but are not limited to, institutional overhead such as heating and air conditioning, lighting, space, and support services of maintenance, housekeeping, and security. Such services are necessary and ongoing whether a teaching session is in progress or not. **Hidden costs**, which are a type of indirect cost, cannot be anticipated or accounted for until after the fact. For example, low productivity of one or more nursing personnel can have a significant impact on the workload of other nurses, which can result in employee turnover that increases recruitment and employee orientation costs.

In a classic description of understanding costs, Gift (1994) makes a point of distinguishing between costs—direct or indirect—and charges. As just described, direct and indirect costs are those expenses incurred by the facility. Charges are set by the provider, but they are billed to the recipient of the services. There may or may not be equivalence between costs and charges. In the retail business, for example, if costs of raw materials are low, and charges for the items, goods, or services are high, the retailer realizes a profit. In the healthcare arena, not-for-profit organizations are limited by federal law as to the amount they can charge in relation to the actual cost of a service. In many instances, particularly as it relates to pharmaceutical goods, the actual cost to the facility is what is charged. As such, the facility provides a service but realizes no financial profit (Kaiser Family Foundation, 2005). Gift explains the different types of costs incurred by healthcare institutions and Cosgrove et al. (2013) outlines strategies to lower costs, improve quality of care, and engage patients in self-management of their own care.

Cost Savings, Cost Benefit, and Cost Recovery

Patient teaching is mandated by state laws, professional and institutional standards, accrediting body protocols, and regulations for participation in Medicare and Medicaid reimbursement programs. However, unless education is ordered by a physician, patient education costs are generally not recoverable as a separate entity under third-party reimbursement. Even though the costs of educational programs, for both patients and nursing staff, are legitimate expenses to the facility, these costs usually are subsumed under hospital room rates and, therefore, are technically absorbed by the healthcare organization. In addition to incurring costs, the institution may also generate revenue from the programs and services it offers. Gift (1994) describes three ways as follows for healthcare institutions to make a profit based on the ratio between costs to charges.

Cost savings are realized when patient lengths of stay in a hospital are shortened or fall within the allotted diagnosis-related group (DRG) time frames (CMS, 2016). Patients who have fewer complications and use less expensive services will yield a cost savings for the institution. In both hospital and ambulatory care settings, cost savings may occur when patient education keeps people healthy and independent for a longer time, thereby preventing high use of staff and expensive diagnostic testing when a patient requires frequent outpatient visits or hospital readmissions. If patients, for example, are readmitted too soon for inpatient services, hospitals can be penalized by HCFA/CMS through citation or loss of payment, in which case any cost savings may be offset by the amount of revenue lost. Thus, efficient and effective patient education is an essential measure that can contribute to reducing overutilization of resources and helping hospitals generate a profit.

Cost benefit occurs when there is increased patient satisfaction with the services

an institution provides, including educational programs such as childbirth classes, weight- and stress-reduction sessions, and cardiac fitness and rehabilitation programs. Patient satisfaction is critical to the individual's return for future healthcare services. Such programs may represent an opportunity for an institution to capture a patient population for lifetime coverage.

Cost recovery results when either the patient or the insurer pays a fee for educational services that are provided. Cost recovery may be captured by offering health education programs for a fee. Also, under Medicare and Medicaid guidelines, reimbursement may be made for programs and services if they are deemed reasonable, appropriate, and necessary to treat a person's illness or injury (Kaiser Family Foundation, 2005). The key to success in obtaining third-party reimbursement is the ability to demonstrate that, due to education, patients can manage self-care at home and consequently experience fewer hospitalizations.

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

To offset the dilemma of striving for cost containment and solvency in an environment of shrinking fiscal resources, healthcare organizations have developed alternative strategies for patient education to realize cost savings, cost benefit, cost recovery, or revenue generation. For example, Cosgrove et al. (2013) outlined 10 key strategies, including patient-centered communication and advanced patient education, that were found to be associated with not only improved clinical outcomes, patient engagement, and higher

patient satisfaction rates, but also a reduction in the cost of delivering care, which is quickly becoming a business imperative.

Program Planning and Implementation

The key elements to consider when planning a patient education offering intended for generation of revenue include an accurate assessment of direct costs such as paper supplies, printing of program brochures, publicity, rental space, and professional time (based on an hourly rate) required of nurses to prepare and offer the service. If an hourly rate is unknown, a simple rule of thumb is to divide the annual base salary by 2080, which is the standard number of hours for which people working full time are paid during one year.

If the program is to be offered at the facility, there may be no need to plan for a rental fee for space. However, indirect costs such as housekeeping, lighting, and security should be factored in as an expense. Such a practice not only is good fiscal management but also provides an accounting of the contributions of other departments to the educational efforts of the facility.

Fees for a program should be set at a level high enough to cover the aggregate costs of program preparation and delivery. If an education program is intended to result in cost savings for the facility, such as education classes for patients with diabetes to reduce the number of costly hospital admissions, then the aim may be to break even on costs. In such a case, the price is set by dividing the calculated cost of the program by the number of anticipated attendees. If the goal is for the institution to improve cost benefits, then success can be measured by increased patient satisfaction (as determined by questionnaires or evaluation forms) or by increased use of the facility's services (as determined by recordkeeping). If the intent is to offer a series of classes for smoking cessation or childbirth preparation to improve

the wellness of the community and to generate income for the facility, then the fee is set higher than cost to make a profit (cost recovery). An annual report to administration of the time and money spent on education efforts in outpatient and inpatient care units may be required to determine if the institution made a profit in terms of cost savings, cost benefit, or cost recovery (Demeere et al., 2009).

Cost-Benefit Analysis and Cost-Effectiveness Analysis

In most healthcare organizations, the education department bears the major responsibility for staff development, for inservice employee training, and for patient education programs that exceed the boundaries of bedside instruction. Total budget preparation for these departments is best explained by the experts in the field. Demeere et al. (2009), for example, address the need for patient care units to engage in responsibility-centered budgeting, which also is referred to as activity-based costing. Given the shift away from providing at-will services and toward greater demand for cost accountability for services performed, these authors propose a model for costing out programs that allows patient care units to identify and recoup their true costs while responding to increased market competition.

There is no single best method for measuring the effectiveness of patient education programs. Most experts in the field tend to rely on determining actual costs or actual impact of programs in relationship to outcomes by employing one of two concepts: cost-benefit analysis (CBA) or cost-effectiveness analysis (CEA) (Abruzzese, 1992). These are two economic evaluation techniques that can be used by healthcare programs that examine the costs and consequences of two or more interventions (Adhikari, 2018).

Cost-benefit analysis measures the relationship between costs and outcomes (Russell,

2015). Outcomes can be the actual amount of revenue generated resulting from an educational offering, or they can be expressed in terms of shorter patient stays or reduced hospitalizations for specific diagnostic groups of patients. If, under DRGs or capitation methods of reimbursement, the facility makes a profit, this outcome can be expressed in monetary terms. If an analysis reveals that an educational program costs less than the revenue it generates, that expense can be recovered by third-party reimbursement. When savings exceed costs, then the program is considered a cost benefit for the facility. The measurement of costs against monetary gains is commonly referred to as the **cost-benefit ratio**, which is the cost of education per patient divided by the total savings per patient (EuroMed Info, 2017).

Cost-effectiveness analysis measures the impact of an educational offering on patient behavior. If program objectives are achieved, as evidenced by positive and sustained changes in the behavior of the participants over time, the program is said to be cost effective (Russell, 2015). Although behavioral changes are highly desirable, in many instances they are less observable, less tangible, and not easily measurable. For example, reduction in patient anxiety cannot be converted into a gain in real dollars. Consequently, it is wise to analyze the outcome of teaching interventions by comparing behavioral outcomes between two or more programs to identify the one that is most effective and efficient when actual costs cannot be determined.

A nurse as educator may be called upon to interpret the costs of behavioral changes (outcomes) to the institution by conducting a cost-effectiveness analysis between programs. This can be accomplished by first identifying and itemizing for each program all direct and indirect costs, including any identifiable hidden costs. Second, it is necessary to identify and itemize any benefits derived from the program offering, such as revenue gained or decreased readmission rates that can be

Exhibit 2-1 Cost-Effectiveness Grid

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

expressed in monetary values. Results of these findings can then be recorded on a grid so that each program's cost-effectiveness is visually apparent (**Exhibit 2-1**).

State of the Evidence

Practice driven by evidence is defined as practice “based on research, clinical expertise, and patient preferences that guide decisions about the healthcare of individual patients” (Hospice and Palliative Nursing Association, 2004, p. 66). Much evidence suggests that ethical principles and theories play a highly significant role in shaping contemporary healthcare delivery practices and decision making. Whereas complex and technological advances in health care have given rise to numerous questions about what is right or wrong—or morally or ethically defensible—few situations yield clear-cut or perfectly right answers to solving a problem or need. Numerous case studies, books, and articles have addressed the challenge of dealing with ethical dilemmas in health care. They attempt to provide evidence for how to deliver health care, including patient education, in the most equitable and beneficial manner

possible. Our increasingly multicultural and pluralistic society is being asked to address the vast array of biomedical ethical issues confronting healthcare practitioners daily in a way that preserves an individual's rights but also protects the well-being of other persons, groups, and communities.

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

Further comparative analysis research needs to be conducted to determine which types of patient education programs are the most equitable, beneficial, and cost effective for patients, nursing staff, the institution, and the communities served. Evidence is scarce on the economics associated with various approaches to education and the value of the nurse educator's role as it affects behavioral outcomes related to cost savings, cost benefit, and cost recovery.

Summary

Ethical and legal dimensions of human rights provide the justification for patient education, particularly as it relates to issues of self-determination and informed consent. These rights are enforced through federal and state regulations and through performance standards promulgated by accrediting bodies and professional organizations for implementation at the local level. The nurse's role as

educator is legitimized through the definition of nursing practice as set forth by the prevailing nurse practice act in the state where the nurse is licensed and employed and by codes of ethics governing professional conduct in various employment settings. In this respect, patient education is a nursing duty that is grounded in justice; that is, the nurse has a legal responsibility to provide education to all patients, regardless of their age, gender, culture, race,

ethnicity, literacy level, religious affiliation, or other defining attributes. All patients have a right to receive health education relevant to their physical and psychosocial needs. Justice also dictates that education programs be designed not only to be consistent with organizational goals but most important to meet the needs of patients to be informed, self-directed, and in control of their own health, and ultimately of their own destiny.

Review Questions

1. What are the definitions of the terms *ethical*, *moral*, and *legal*, and how do they differ from one another?
2. Which national, state, professional, and private-sector organizations legislate, regulate, and provide standards to ensure the protection of human rights in matters of health care?
3. Which ethical viewpoint, deontological or teleological, refers to the decision-making approach that choices should be made for the common good of people?
4. How are the six ethical principles applied to the delivery of patient education?
5. What are four examples of direct costs and five examples of indirect costs in the provision of patient/staff education?
6. What are the definitions of the following terms: *fixed direct costs*, *variable direct costs*, *indirect costs*, *cost savings*, *cost benefit*, *cost recovery*, *revenue generation*, *cost-benefit analysis*, *cost-benefit ratio*, and *cost-effectiveness analysis*?

CASE STUDY

Katelyn is a new RN working the night shift on a medical/surgical unit. Mr. Williams, a patient in a room next to Katelyn's assigned area, has been setting off the bed alarm all night, and other patients are starting to complain about the disturbance. Katelyn goes in to assist the nurse, Arlene, who is in the room trying to control the situation. Mr. Williams is out of bed, clearly confused and disoriented, claiming that he is being held hostage and needs to get out of there. Katelyn helps Arlene get the patient back into bed safely, but it is clear he is not going to stay there for long. Arlene is clearly flustered and says, "I've had enough!" before hurrying out of the room and returning with four-point restraints. She turns to Katelyn and states, "The doctor won't give me any more medication to put this patient down, so I am putting these on him just to have time to get some charting done. I'll take them off in the morning before anyone sees." Katelyn knows that Arlene does not have an order for restraints and that they can cause harm to the patient, especially when not used appropriately.

1. What plausible actions should Katelyn take at this point?
2. Which legal and ethical reasons could Katelyn rely on to justify the actions she takes?
3. Which of Katelyn's actions seem the most justified from a moral and ethical standpoint?

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