Ethical, Legal, and Economic Foundations of the Educational Process

M. Janice Nelson

CHAPTER HIGHLIGHTS

A Differentiated View of Ethics, Morality, and the Law
Evolution of Ethical and Legal Principles in Health Care
Application of Ethical and Legal Principles to Patient Education
  Autonomy
  Veracity
  Confidentiality
  Nonmalfeasance
  Beneficence
  Justice
Legality of Patient Education and Information Documentation
Economic Factors of Patient Education: Justice and Duty Revisited
Financial Terminology
  Direct Costs
  Indirect Costs
Cost Savings, Cost Benefit, and Cost Recovery
Program Planning and Implementation
Cost-Benefit Analysis and Cost-Effectiveness Analysis
State of the Evidence

KEY TERMS

- ethical
- moral
- legal
- autonomy
- veracity
- confidentiality
- nonmalfeasance
- negligence
- malpractice
- beneficence
- justice
- respondeat superior
- direct costs
- fixed costs
- variable costs
- indirect costs
- cost savings
- cost benefit
OBJECTIVES

After completing this chapter, the reader will be able to

1. Identify the six major ethical principles.
2. Distinguish between ethical and legal dimensions of the healthcare delivery system, including patient and staff education.
3. Describe the importance of nurse practice acts.
4. Describe the legal and financial implications of documentation.
5. Delineate the ethical, legal, and economic importance of federal, state, and accrediting body regulations and standards in the delivery of healthcare services.
6. Differentiate among financial terms associated with the development, implementation, and evaluation of patient education programs.

Today as never before in the evolution of the healthcare field, there is 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 quality standard of care, to informed consent, and subsequently to self-determination. Consequently, it is crucial that the providers of care be equally proficient in both educating the public and in educating nursing students and staff who are or will be the practitioner educators of tomorrow.

Although the physician is primarily held legally accountable for 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 absolutely essential and mandated as such through a variety of state nurse practice acts.

We are indeed living in an age of an enlightened public that is not only aware, but also demands recognition of individual constitutional rights regarding freedom of choice and rights to self-determination. In fact, it may seem curious to some that federal and state governments, accrediting bodies, and professional organizations find it necessary to legislate, regulate, or provide standards and guidelines to ensure the protection of human rights when it comes to matters of health care. The answer, of course, is that the federal government has abandoned its historical hands off policy toward physicians and other health professionals in the wake of serious breaches of public confidence and shocking revelations of abuses of human rights in the name of biomedical research.

These issues of human rights are fundamental to the delivery of 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 make informed choices and to be in control of the consequences of those choices regardless of the outcome. Thus, in explicating the role of the nurse in the teaching–learning process, it would be remiss to omit the ethical and legal foundations of that process. Also, in the interest of justice, which refers to the equal distribution of benefits and burdens, it is important to acknowledge the relationship of costs to the healthcare facility in the provision of such services. Teaching and learning principles, with their inherent legal and ethical dimensions, apply to any situation in which the educational process is occurring.

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

A Differentiated View of Ethics, Morality, and the Law

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

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

Although multiple perspectives on the rightness or wrongness of human acts exist, among the most commonly referenced are the writings of the 16th-century German philosopher, Immanuel Kant, and those of the 19th-century English scholar and philosopher, John Stuart Mill (Edward, 1967). Kant proposed that individual rights prevail and openly proclaimed the deontological notion of the “Golden Rule.” Deontology (from the Greek word deon, which means duty) is the ethical belief system that stresses the importance of doing one’s duty and following the rules. Thus, respect for individual rights is key and one person should never be treated merely as a means to another person’s benefit or a group’s well-being (Tong, 2007). Mill, on the other hand, proposed the teleological notion or utilitarian
approach to ethical decision making that allows for the sacrifice of one or more individuals so that a group of people can benefit in some important way. He believed that given the alternatives, choices should be made that result in the greatest good for the greatest number of people.

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

Ethics refers to the guiding principles of behavior, and ethical refers to norms or standards of behavior. Although the terms moral or morality are generally used interchangeably with the terms ethics or ethical, one can differentiate the notion of moral rights and duties from the notion of ethical rights and duties. Moral refers to an internal value system (the moral fabric of one’s being) and this value system, defined as morality, is expressed externally through ethical behavior. Ethical principles deal with intangible moral values, so they are not enforceable by law, nor are these principles laws in and of themselves. Legal rights and duties, on the other hand, refer to rules governing behavior or conduct that are enforceable under threat of punishment or penalty, such as a fine, imprisonment, or both.

The intricate relationship between ethics and the law explains why ethics terminology, such as informed consent, confidentiality, non-malfeasance, and justice, can be found within the language of the legal system. 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. In reality, the legitimacy of this role stems from the nurse practice act that exists in the particular state where the nurse resides, is licensed, and is employed. In essence, the nurse practice act is not only legally binding, but it is also protected by the police authority of the state in the interest of protecting the public (Brent, 2001; Mikos, 2004).

**Evolution of Ethical and Legal Principles in Health Care**

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

Although there are numerous court records of lawsuits involving hospitals, physicians, and nurses dating back to the early 1900s, those numbers pale in comparison with the volumes being generated on a daily basis in today’s world.
Evolution of Ethical and Legal Principles in Health Care

(Reising & Allen, 2007). Further, despite the horror stories that have been handed down through the years regarding inhumane and often torturous treatment of prisoners, the mentally infirm, the disabled, and the poor, there was limited focus in the past on ethical aspects of that care. In turn, there was little thought of legal protection for the rights of such mentally, physically, or socioeconomically challenged people.

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

Over the years, legal authorities such as federal and state governments maintained a hands-off posture when it came to issues of biomedical research or physician–patient relationships. However, human atrocities committed by the Nazis in 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 alone. On United States soil, for example, the nontreatment of syphilitic African Americans 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 mentally retarded children to test hepatitis vaccines at Willowbrook Developmental Center on Staten Island, New York, shocked the nation and raised a critical consciousness 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 (Department of Health and Human Services [DHHS], 1983). As an outcome of this unprecedented act, an institutional review board for the protection of human subjects (IRBPHS) was rapidly established at the local level by hospitals, academic medical centers, and any agency or organization where research on human subjects was being conducted. To this day, the primary emphasis of these review boards is on confidentiality, truth telling, and informed consent, with specific concern for vulnerable populations such as infants, children, prisoners, and the mentally ill. Every proposal for biomedical research that involves human subjects must be submitted to a local IRBPHS for intensive review and approval before proceeding with a proposed study (DHHS, 1983). Further, in response to its concern about the range of ethical issues associated with medical practice and a perceived need to regulate biomedical research, in 1978 Congress established the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (Brent, 2001; DHHS, 1983; Thomas & Quinn, 1991).

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

In 1975, the American Hospital Association (AHA) followed suit by disseminating a document entitled Patient’s Bill of Rights, which was revised in 1992 (Association of American Physicians and Surgeons, 1995). A copy of these patient rights is framed and posted in a public place in every healthcare facility across the United States. In addition, federal standards developed by the Center for Medicare and Medicaid Services (CMS)—an arm of the Health Care Financing Administration (HCFA)—require that the patient be provided with a personal copy of these rights either at the time of admission to the hospital or long-term care facility or prior to the initiation of care or treatment when admitted to a surgicenter, an HMO, home care, or a hospice. As a matter of fact, many states have adopted the statement of patient rights as part of their state health code. Thus these rights fall under the jurisdiction of the law, rendering them legally enforceable by threat of penalty.

Application of Ethical and Legal Principles to Patient Education

In considering the ethical and legal responsibilities inherent in the process of patient education, six major ethical principles are intricately woven throughout the ANA’s Code of Ethics (2001), the AHA’s Patient’s Bill of Rights (1992), and similar documents promulgated by other healthcare organizations as well as the federal government. These principles, which encompass the very issues that precipitated federal intervention into healthcare affairs, are autonomy, veracity, confidentiality, nonmalfeasance, beneficence, and justice.

Autonomy

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

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

One principle worth noting in the ANA's Code of Ethics is that which addresses collaboration “with members of the health professions and other citizens in promoting community and national efforts to meet the health needs of the public” (New York State Nurses Association, 2001, p. 6). Although not specified in such detail in the ANA document, 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. While 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 statements identifying health education as a legal duty and responsibility of the registered nurse.

Veracity

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

Cisar and Bell (1995) addressed this concept of battery related to medical treatment exceedingly well. In addition to explaining Curtin's (1978) Ethical Decision-Making Model, which serves as a guide for healthcare providers facing an ethical dilemma, the authors offered the following explanation of the four elements making up the notion of informed consent that are such vital aspects of patient education:

1. Competence, which refers to the capacity of the patient to make a reasonable decision.
2. Disclosure of information, which requires that sufficient information regarding risks and alternative treatments be provided to the patient to enable him or her to make a rational decision.
3. Comprehension, which speaks to the individual's ability to understand or to grasp intellectually the information being provided. A child, for example, may not yet be of an age to understand
any ramifications of medical treatment and must, therefore, depend on his or her parents to make a decision that will be in the child’s best interest.

4. Voluntariness, which indicates that the patient has made a decision without coercion or force from others.

While all four of these elements might be satisfied, the client might still choose to reject the regimen of care suggested by healthcare providers. This decision could be due to the exorbitant cost of a treatment or to certain personal or religious beliefs. Whatever the case, it must be recognized by all concerned that a competent, informed client cannot be forced to accept treatment as long as he or she is aware of the alternatives as well as the consequences of any decision (Cisar & Bell, 1995).

A final 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 particular 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). In any case, the concept of expert testimony speaks for itself. Regardless of the situation, the nurse must always tell the truth and the client (or his or her health proxy) is always entitled to the truth (Hall, 1996).

Confidentiality

Confidentiality refers to personal information that is entrusted and protected as privileged information via a social contract, healthcare standard or code, or legal covenant. Such information may not be disclosed by healthcare providers when acquired in a professional capacity from a patient without consent of that patient. If sensitive information were not to be protected, patients would lose trust in their providers and would be reluctant to openly share problems with them.

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

Only under special circumstances may secrecy be ethically broken, such as when a patient has been the victim or subject of a crime to which the nurse or doctor is a witness (Lesnick & Anderson, 1962). Other exceptions to confidentiality occur when professionals suspect or are aware of child or elder abuse, narcotic use, communicable diseases, gunshot or knife wounds, or the threat of violence toward someone. To protect the welfare of others, professionals are permitted to breach confidentiality. Another example occurs when a patient tests positive for HIV/AIDS and has no intention of telling his or her spouse about this diagnosis. In this instance, the physician is obligated to warn the spouse directly or indirectly of the risk of potential harm (Tong, 2007).

According to Brent (2001), “this area of legislation concerned with health care privacy and disclosure reveals the tension between what is good for the individual vis-à-vis what is good for society” (p. 141).

The 2003 updated Health Information Portability and Accountability Act (HIPAA) ensures nearly absolute confidentiality related to dissemination of patient information, unless the patient himself or herself authorizes release of such information (Kohlenberg, 2006). One goal of the HIPAA policy, first enacted by Congress
Application of Ethical and Legal Principles to Patient Education

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 elevator conversations about private matters of individuals entrusted to our care. In an open, liberal, and technologically advanced society such as ours, this law is a must to ensure confidentiality (Tong, 2007). Today, in some states and under certain conditions, such as death or impending death, a spouse or members of the immediate family can be apprised of the patient’s condition if this information was previously unknown to them. Despite federal and state legislation protecting the confidentiality rights of individuals, the issue of the ethical/moral obligation of the person with HIV/AIDS or genetic disease, for example, to voluntarily divulge his or her condition to others who may be at risk remains largely unresolved (Legal Action Center, 2001).

Nonmalfeasance

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

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

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

The concept of duty is closely tied to the concepts of negligence and malpractice. Nurses’ duties are spelled out in job descriptions at their places of employment. Policy and procedure
manuals of a particular facility exist certainly to protect the patient, but they also exist to protect 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 a particular institution and can be used in a court of law in the determination of negligence.

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

In the instance of litigation, the key operational principle is that the nurse is not measured against the optimal or maximum of professional standards of performance; rather, the yardstick is laid against the prevailing practice of what a prudent and reasonable nurse would do under the same circumstances in a given community. Thus, the nurse’s duty of patient education (or lack thereof) is measured against not only prevailing policy of the employing institution, but also against prevailing practice in the community. In the case of clinical nurse specialists (CNSs), nurse practitioners (NPs), or clinical education specialists (CESs), for example, 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 adherence to critical tasks and duties contained in job descriptions; in policies, procedures, and protocols set forth by the healthcare facility; and in standards and codes of ethical behaviors established by professional nursing organizations. Adherence to these various professional performance criteria and principles, including adequate and current patient education, speaks to the nurse’s commitment to acting in the best interest of the patient. Such behavior emphasizes patient welfare, but not necessarily to the detriment of the well-being of the healthcare provider. That is, the effort to save lives and relieve human suffering is a duty to do good only within reasonable limits. For example, when AIDS first appeared, the cause and control of this fatal disease was unknown. Some healthcare professionals protested that the duty of beneficence did not include caring for patients who put them at risk for this deadly, infectious, and untreatable disease. Once it became clear that transmission through occupational exposure was quite small, the majority of healthcare practitioners concurred with the opinion of the American Medical Association that they “… may not ethically refuse to treat a patient whose condition is within [their] current realm of competence solely because the patient is seropositive” (Tong, 2007).

**Justice**

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

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

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

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

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

Most recently, the U.S. Congress has wrestled with another version of patients’ rights within which every American carrying health insurance is guaranteed access to emergency room care, to treatment by medical specialists, and to government-run clinical trials (Abood, 2001; President’s Advisory Commission on Consumer Protection and Quality in the Healthcare Industry, 1998). Also, considerable argument has ensued among members of Congress over the extent to which health maintenance organizations (HMOs) can be sued for delay or denial of care, and what limits, if any, should be placed on the damages (Zuckerman, 2001). This federal legislation adds an interesting dimension to the notion of justice as it applies to health care. The proposed patients’ rights legislation is intended only for those covered by health insurance. This restriction raises serious questions for the uninsured regarding the right of access to health care and subsequently the right of access to 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 of delivery systems and investing in expensive and elaborate information systems. HMOs have bought out physician practices and have become involved in a number
of related activities with no substantial evidence that a high quality of health care will be achieved at lower prices.

To date, this particular enactment of a patient’s bill of rights and the issues of just or unjust cost-cutting activities of HMOs as described by Emanuel (2000) do, indeed, affect the role of the educator. These issues determine whether nurse educators can surmount the obstacles potentially blocking the patient education process. In the interest of cutting costs, HMOs have also succeeded in shortening lengths of hospital stays. This development, in turn, has had a tremendous effect on the delivery of education to the hospitalized patient and presents serious obstacles to the implementation of this mandate. Lack of time serves as a major barrier to the nurse in being able to provide sufficient information for self-care, and illness acuity level interferes with the patient’s ability to process information necessary to meet his or her physical and emotional needs.

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

**Legality of Patient Education and Information**

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

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

Federal authorities have generally tended to hold physicians responsible and accountable for proper patient education. This is particularly true as it pertains to issues of informed consent, such as those highlighted in *Scalia v. St. Paul Fire and Marine Ins. Co.*, 1975 (Smith, 1987). It is a well-known fact—at least in hospitals—that patient education usually is carried out by the nurse or some other physician-appointed de-
signee. Physicians’ responsibility notwithstanding, from a professional and legal vantage point, nurses are fully legitimized in their role as patient educators by virtue of their respective 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 (or the lack thereof) that provides evidence of written testimony that client education has indeed occurred.

Documentation

The 89th Congress enacted the Comprehensive Health Planning Act in 1965, Public Law 89-97, 1965 (Boyd, Gleit, Graham, & Whitman, 1998). The entitlements of Medicare and Medicaid—which revolutionized the provision of health care for the elderly and the poor—were established through this act. One acknowledgment in the act was the importance of the preventive and rehabilitative dimensions of health care. Thus, to qualify for Medicare and Medicaid reimbursement, “a hospital has to show evidence that patient education has been a part of patient care” (Boyd et al., 1998, p. 26).

For at least the past 20 years, the Joint Commission (formerly JCAHO) has reinforced the federal mandate by requiring evidence (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).

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

Furthermore, documentation is a vehicle of communication that provides critical information to other healthcare professionals involved with the patient’s care. Failure to document not only renders other staff potentially liable, but also renders the facility liable and in jeopardy of losing its Joint Commission accreditation. Concomitantly, the institution is also in danger of losing its appropriations for Medicare and Medicaid reimbursement.

In any litigation where the doctrine of respondeat superior is applied, outcomes can hold the organization liable for damages (monetary retribution). Thus it behooves the nurse as both employee and professional not only to provide patient education, but also to document it appropriately and to be critically conscious of the legal and financial ramifications to the healthcare facility in which he or she is employed.
Chapter 2: Ethical, Legal, and Economic Foundations

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

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

The form provides documentation space for who was taught (e.g., client or family), what was taught (e.g., self-injection of insulin), when it was taught, what strategies of teaching were used (instructional methods and materials), and how the client responded to instruction (what outcomes were achieved).

Table 2–1 is a visual representation of the relationship of ethical principles to the laws and professional standards applicable to each principle. It should be noted that the AHA’s 1975 original draft rendition of a Patient’s Bill of Rights, along with all the later renditions of these rights, are linked to or associated with every ethical principle. The Patient’s Bill of Rights (AHA, 1992) is rooted in the conditions of participation in Medicare set forth under federal standards established by the Center for Medicare and Medicaid Services (CMS). These standards are further emphasized by corresponding accreditation standards promulgated by the Joint Commission. All these laws and professional standards serve to ensure the fundamental rights of every person as a consumer of healthcare services.

Economic Factors of Patient 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 this phenomenon. Others would agree that in addition to the legal considerations that mandate adherence to regulations in health care regardless of the economics involved, there is also an ethical dimension that speaks certainly to quality of care and also to justice, which refers to the equal distribution of goods and services.

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

Thus, as an employee of the provider organization, the nurse has a duty to carry out organizational policies and mandates by acting in an accountable and responsible manner. This duty includes assuming fiscal accountability for patient education activities, whether these are offered on an inpatient or ambulatory care basis or as a service to the larger community.

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

Table 2–1  Linkages Between Ethical Principles and the Law

<table>
<thead>
<tr>
<th>Ethical Principles</th>
<th>Legal Actions/Decisions and Standards of Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autonomy (self-determination)</td>
<td>Cardozo decision regarding informed consent</td>
</tr>
<tr>
<td></td>
<td>Institutional review boards</td>
</tr>
<tr>
<td></td>
<td>Patient Self-Determination Act</td>
</tr>
<tr>
<td></td>
<td>Patient’s Bill of Rights</td>
</tr>
<tr>
<td></td>
<td>Joint Commission/CMS standards</td>
</tr>
<tr>
<td>Veracity (truth telling)</td>
<td>Cardozo decision regarding informed consent</td>
</tr>
<tr>
<td></td>
<td>Patient’s Bill of Rights</td>
</tr>
<tr>
<td></td>
<td>Tuma decision</td>
</tr>
<tr>
<td></td>
<td>Joint Commission/CMS standards</td>
</tr>
<tr>
<td>Confidentiality (privileged info)</td>
<td>Privileged information</td>
</tr>
<tr>
<td></td>
<td>Patient’s Bill of Rights</td>
</tr>
<tr>
<td></td>
<td>Joint Commission/CMS standards</td>
</tr>
<tr>
<td>Nonmalfeasance (do no harm)</td>
<td>Malpractice/negligence rights and duties</td>
</tr>
<tr>
<td></td>
<td>Nurse practice acts</td>
</tr>
<tr>
<td></td>
<td>Patient’s Bill of Rights</td>
</tr>
<tr>
<td></td>
<td>Darling v. Charleston Memorial Hospital</td>
</tr>
<tr>
<td></td>
<td>State health codes</td>
</tr>
<tr>
<td></td>
<td>Joint Commission/CMS standards</td>
</tr>
<tr>
<td>Beneficence (doing good)</td>
<td>Patient’s Bill of Rights</td>
</tr>
<tr>
<td></td>
<td>State health codes</td>
</tr>
<tr>
<td></td>
<td>Job descriptions</td>
</tr>
<tr>
<td></td>
<td>Standards of practice</td>
</tr>
<tr>
<td></td>
<td>Policy and procedure manuals</td>
</tr>
<tr>
<td></td>
<td>Joint Commission/CMS standards</td>
</tr>
<tr>
<td>Justice (equal distribution of benefits and burdens)</td>
<td>Patient’s Bill of Rights</td>
</tr>
<tr>
<td></td>
<td>Antidiscrimination/affirmative action laws</td>
</tr>
<tr>
<td></td>
<td>Americans with Disabilities Act</td>
</tr>
<tr>
<td></td>
<td>Joint Commission/CMS standards</td>
</tr>
</tbody>
</table>
On the one hand, the realities of capitation and managed care result in shrinking revenues. This trend, in turn, dictates shorter patient stays in hospitals and doing more with less. Despite continued, severe shortages of healthcare personnel in most geographic areas of the country, healthcare facilities are concomitantly expanding their clinical expertise into satellite types of ambulatory and home care services. On the other hand, these same organizations are held to the exact standards of care that are underwritten by the Patient’s Bill of Rights (AHA, 1992), which is regulated as a contingency of Medicare and Medicaid participation by the CMS and for agency accreditation by the Joint Commission. In turn, although there are some exceptions (e.g., home healthcare agencies), hospital accreditation in particular dictates eligibility for third-party reimbursement in both the public and private sectors.

Over and above the financial facts, these same charitable, not-for-profit organizations no longer enjoy the legal immunity that existed in yesterday. The doctrine of respondeat superior is alive and well. In a Supreme Court decision stemming from Abernathy v. Sisters of St. Mary’s in 1969, the court held that a “non-governmental charitable institution is liable for its own negligence and the negligence of its agents and employees acting within the scope of their employment” (Strader, 1985, p. 364). The court further declared that this ruling would apply to all future cases as of November 10, 1969. Thus the regulated right of clients to health education carries a corresponding duty of healthcare organizations to provide that service.

In an environment of shrinking healthcare dollars, continuous shortages of staff, and dramatically shortened lengths of stay yielding rapid patient turnover, the organization is challenged to ensure the competency of nursing staff to provide educational services, and to do so in the most efficient and cost-effective manner possible. This is an interesting dilemma when considering the fact that patient education is invariably identified, directly or indirectly, as a legal responsibility of registered nurses in the respective nurse practice acts of all states. Unfortunately, few, if any, prelicensure education programs adequately prepare nursing students for this critical function.

Financial Terminology

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

Direct Costs

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

Because of the labor-intensive function of 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 thus, the higher the institution’s total direct costs.

Although the purpose of salary is to buy an employee’s time and particular expertise, it is often difficult to predict how long it will take to
Financial Terminology

plan, implement, and evaluate various educational programs being offered. For example, if planning and carrying out patient or staff education exceeds the allocated time and the nurse educator draws overtime pay, the extra cost may not have been anticipated in the budget planning process.

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

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

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

Variable costs are those costs that, in the case of healthcare organizations, depend on volume. The number of meals prepared, for example, depends on the patient census. From an educational perspective, the demand for patient teaching depends on the number and diagnostic types of hospitalized patients. For example, if the volume of cardiac bypass surgical patients is low, educational costs may be high due to the fact that intensive one-to-one instruction would need to be offered to each patient admitted. Conversely, if the volume of bypass surgeries is high, it is less expensive to provide standardized programs of instruction via group teaching sessions for these cardiac clients. As another example, if demand or turnover of nursing staff increases, the number of orientation sessions for new employees would also increase in volume. Supplies, also a direct, variable cost, can change depending on the amount and type needed. Variable costs can become fixed costs when volume remains consistently high or low over time.

Indirect Costs

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

Hidden costs, a type of indirect cost, can neither be anticipated nor accounted for until after the fact. Low employee productivity can produce hidden costs. Organizational budgets are prepared on the basis of what is known and predictable, with projections for variability in patient census included. Personnel budgets are based on levels of staff needed (e.g., number of RNs, LPNs and nursing assistants) to accommodate the expected patient volume. This is determined by an annual projection of patient days and how many patients an employee can effectively care for on a daily basis. Low productivity of one or two personnel on a nursing unit, for example, can have a
significant impact on the workload of others, which, in turn, leads to low morale and employee turnover. Turnover increases recruitment and new employee orientation costs. In this respect, the costs are appropriately identified as hidden.

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

**Cost Savings, Cost Benefit, and Cost Recovery**

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

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

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

*Cost recovery* results when either the patient or insurer pays a fee for educational services that are provided. Cost recovery is realized through the marketing of health education programs offered for a fee.

Under Medicare and Medicaid guidelines, reimbursement may be made for programs “furnished by providers of services to the extent that the programs are appropriate, integral parts in the rendition of covered services which are reasonable and necessary for the treatment of the
individual’s illness or injury” (Kaiser Family Foundation, 2005). The key to success in obtaining third-party reimbursement is the ability to demonstrate that as a result of education, patients can manage self-care at home and consequently experience fewer hospitalizations.

To take advantage of cost recovery, hospitals and other healthcare agencies develop and market a cadre of health education programs that are open to all consumers in the community. No matter whether a client is charged in full or pays on a sliding scale for these services, the American mentality is “if it costs something, it must be worth something.” Thus, fee-for-service programs usually are well attended and result in revenues for the institution. The critical element, of course, is not only the recovery of costs but also revenue generation. Revenue generation refers to income realized over and above program costs, which can also be regarded as profit.

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

Program Planning and Implementation

The key elements to consider when planning a patient education offering intended for generation of revenue include an accurate assessment of direct costs such as paper supplies, printing of program brochures, publicity, rental space, and time (based on an hourly rate) required of professional personnel to prepare and offer the service. If an hourly rate is unknown, a simple rule of thumb is to divide the annual base salary by 2080, which is the standard number of hours worked by most people in the course of 1 year.

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

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

Over the course of a year, it is usually necessary for nurse educators to give an annual report to administration of time and money spent and whether such expenditures were profitable to the institution in terms of cost savings, cost benefit, or cost recovery.
Cost-Benefit Analysis and Cost-Effectiveness Analysis

In the majority of healthcare organizations, the education department bears the major responsibility for staff development, for in-service employee training, and for patient education programs that exceed the boundaries of bedside instruction. Total budget preparation for these departments is best explained by the experts in the field. Fisher, Hume, and Emerick (1998), for example, address the need for staff development departments to engage in responsibility-centered budgeting (RCB), which also is referred to as activity-based management (ABM). Given the shift away from providing at-will services and toward greater demand for cost accountability for educational programs, they propose a template for costing out programs that allows staff development departments to identify and recoup their true costs while responding to increased market competition.

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

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

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

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

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

State of the Evidence

Practice that is driven by evidence is defined as being “practice that is based on research, clinical expertise, and patient preferences that guide decisions about the healthcare of individual patients” (HPNA Position Paper, 2004, p. 66). In this chapter, the six ethical principles have been explicated in terms of their relationship to patient education, in particular, and to healthcare services, in general.

Comparatively speaking, the application of ethics (known as applied ethics) to health care is a relatively recent phenomenon. Much evidence suggests that the tried-and-true ethical principles as well as a wide variety of ethical theories play a highly significant role in shaping contemporary healthcare delivery practices and decision making. In our increasingly multicultural and pluralistic society, the challenge is to be able to address the vast array of biomedical ethics issues confronting healthcare practitioners on a daily basis in a way that preserves an individual’s rights but also protects the well-being of other persons, groups, and communities. The complex
Chapter 2: Ethical, Legal, and Economic Foundations

and technological advances in health care have given rise to numerous questions about what is right or wrong, yet very few clear-cut or perfectly right answers have been forthcoming. Numerous case studies, books, and articles on how to deal with ethical dilemmas abound. They attempt to provide evidence for nursing practice, including patient education, about how to deliver care in the most equitable and beneficial manner possible.

Laws and standards that govern the role of the nurse as educator are firmly established and provide the legal foundations and professional expectations in practice for the delivery of quality patient care. Also well established is the importance of documenting nursing interventions, but more research that provides evidence of the frequency and amount of patient education nurses do daily on an informal basis that never gets recorded must be conducted. In addition, although strategies exist for analyzing cost effectiveness and cost benefits as a means to strengthen the value and accountability of the nurse educator to the client and to the employing agency, more research evidence is needed to substantiate the importance of the educator’s role in influencing overall costs of care.

Further research needs to be conducted to determine, through comparative analysis, 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 impacts on 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. In this respect, patient education is a nursing duty that is grounded in justice; that is, the nurse has a legal responsibility to provide patient education and, regardless of their culture, race, ethnicity, and so forth, all clients have a right to health education relevant to their physical and emotional needs. Justice also dictates that education programs should be designed to be consistent with organizational goals while meeting 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 are they distinct from one another?
2. Which national, state, professional, and private-sector organizations legislate, regulate, and provide standards to ensure the protection of human rights in matters of health care?
3. Which ethical viewpoint, deontological or teleological, refers to the decision-making approach that choices should be made for the common good of people?
4. With respect to ethical, moral, and legal obligations, how does the American Hospital Association’s Patient’s Bill of Rights compare to the American Nurses Association’s Code of Ethics for Nurses With Interpretive Statements?
5. What are the six ethical principles that dictate the actions of healthcare providers in delivering services to clients?
6. Why are nurse practice acts so important to nurses in carrying out their roles and responsibilities to the public?
7. What is the difference between the terms negligence and malpractice?
8. When was informed consent established as a basic tenet of ethics and what is the nurse’s role in situations involving informed consent?
9. What is meant by the legal term respondeat superior, and how does this term apply to professional nursing practice?
10. Why is documentation of professional nursing duties, particularly patient education, so important in the provision of care by nurses?
11. What are four examples of direct costs and five examples of indirect costs in the provision of patient/staff education?
12. What are the definitions of these terms: fixed direct costs, variable direct costs, indirect costs, cost savings, cost benefit, cost recovery, cost-benefit analysis, and cost-effectiveness analysis?

References

Abernathy v. Sisters of St. Mary’s, 446 SW2d 559 (MO1969).


Darling v. Charleston Memorial Hospital, 211 NE2d 253 (IL 1965).


Schloendorff v. Society of New York Hospitals, 211 NY, 125, 128, 105 N.E. 92, 93 (1914).


