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Chapter 1 : Rights vs. Responsibilities: Professional Standards and Provider Refusals | Guttmacher Institut

Law and ethics state that the doctor-patient interaction should remain confidential. The physician should never reveal confidential information unless the patient wants this information disclosed to others, or unless required to do so by law.

This article has been cited by other articles in PMC. Abstract Informed consent is a vital document while performing all surgical and aesthetic procedures, particularly in the current day practice. Proper documentation and counseling of patients is important in any informed consent. Mutual trust forms the foundation for good relationship between doctor and patient. Today, patients tend to be well- or ill-informed about the disease and health. No one else has the right to coerce the patient to act in a particular way. No one has the right to even touch, let alone treat another person. Hence, obtaining consent is a must for anything other than a routine physical examination. But, intimate examination, especially in a female, invasive tests and risky procedures require specific expressed consent. Expressed explicit consent[4 , 5] can be oral or written. Written consents are preferable in situations involving long-term follow-up, high-risk interventions and cosmetic procedures and surgeries. It is also needed for skin biopsy, psoralen with ultraviolet A PUVA therapy, intralesional injection, immunosuppressive therapy, electrocautery etc. Specific consent must be taken if the identity of the patient is likely to be revealed while publishing. Consent can be challenged on the ground that adequate information has not been revealed to enable the patient to take a proper and knowledgeable decision. Therefore, accurate, adequate and relevant information must be provided truthfully in a form using non-scientific terms and language that the patient can understand. There must not be any kind of coercion. Consent must be voluntary and patient should have the freedom to revoke the consent. In case of children, consent must be obtained from a parent. In case of incapacitated persons, close family members or legal guardians can give consent. Adequate information should be provided to a prudent patient during informed consent. Prudent patient means a reasonable or average patient. A netizen may expect and demand detailed information. The information provided to a patient should include all material risks. But, the list of risks and side effects cannot be exhaustive to the level of absurdity and impracticality. For example, hardly any patient can go through the product information leaflet included in any drug pack and if some body does, it is unlikely that the drug is consumed. So, what is expected is that the doctor should provide information that a prudent[3] or reasonable patient would expect to make a knowledgeable decision about the course of action to be taken in the presence of alternatives. But, it should be shared with close relatives. This situation usually does not occur in cutaneous aesthetic surgical procedures. Placebo Use of placebos in certain self-limiting conditions or in patients with high psychological overlay or in those who insist for some form of medication[10] is justified as there are high chances of benefit to the patient with negligible risk. Revealing the truth to the patient takes away the very purpose of administration of placebo. It should be specific for a particular event. If, consent is taken for microdermabrasion, it cannot be valid for any other procedure like acid peel. Additional consent will have to be obtained before proceeding with the latter. If a consent form says that patient has consented to undergo laser resurfacing by Dr. X, the procedure cannot be done by Dr. Y, even if Dr. Y or his authorized assistants. It should be prepared in duplicate and a copy handed over to the patient. It should be dated and signed by the patient or guardian, the doctor and an independent witness. Assisting nurse preferably should not be a witness. Like all other medical records, it should be preserved for at least 3 years. If, a doctor diagnoses varicella in a child, the parent may choose to avail no treatment because of religious belief. Such informed refusals must be documented clearly. In an emergency situation, for example intestinal perforation, a doctor may have to operate even in the absence of consent, to save the life of the patient. It is possible that even with such an intervention, the patient may not survive. This protection is given under Section 88 of Indian Penal Code. The level of disclosure has to be case-specific. There cannot be anything called a standard consent form. This is highlighted by the note of The California Supreme Court: Maintaining good relationship with patient often works better than the best informed consent! Footnotes Conflict of

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Interest: Principles of Biomedical Ethics. Oxford University Press; Medical ethics and health care - issues and perspectives. Trehan SP, Sankhari D. Medical professional, patient and the law: National Law School of India University; World Medical Association, Inc. Snyder L, Leffler C. Medical Ethics, A Ready Referencer. Autonomy and Informed Consent, Medical Ethics. Four principles plus attention to scope. Regents of the University of California.

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Chapter 2 : Ethical Responsibilities of Nurses | blog.quintoapp.com

This Code of Ethics is built upon the five roles of the physical therapist (management of patients/clients, consultation, education, research, and administration), the core values of the profession, and the multiple realms of ethical action (individual, organizational, and societal).

And it is on the basis of this concept of the person, and the fundamental dignity and equality of all human beings, that the notion of patient rights was developed. In other words, what is owed to the patient as a human being, by physicians and by the state, took shape in large part thanks to this understanding of the basic rights of the person. Different models of the patient-physician relationshipâ€"which can also represent the citizen-state relationshipâ€"have been developed, and these have informed the particular rights to which patients are entitled. In North America and Europe, for instance, there are at least four models which depict this relationship: Each of these suggests different professional obligations of the physician toward the patient. For instance, in the paternalistic model, the best interests of the patient as judged by the clinical expert are valued above the provision of comprehensive medical information and decision-making power to the patient. The informative model, by contrast, sees the patient as a consumer who is in the best position to judge what is in her own interest, and thus views the doctor as chiefly a provider of information. There continues to be enormous debate about how best to conceive of this relationship, but there is also growing international consensus that all patients have a fundamental right to privacy, to the confidentiality of their medical information, to consent to or to refuse treatment, and to be informed about relevant risk to them of medical procedures. But there remains a great deal of work to be done to clarify the relationship between human rights and right to health, including patient rights. Recognizing this challenge, the United Nations Commission on Human Rights UNHCR has designated a Special Rapporteur to provide it with a report that examines and clarifies the broader relationship between human rights and the right to health. Grounding this mission in a fundamental human right to health would be an important milestone, and a great step forward realizing this goal. Genomics-based research and genetic technologies raise concerns, however, in relation to several of these issues. For instance, ensuring the confidentiality of genetic information, given its bearing on the health of relatives and sometimes of communities, presents a particular challenge, as does communicating genetic risk, which often involves probabilities rather than certainties. Individuals may therefore have reservations about the use of genetic information by third parties and possible harm that could result, including the denial of health or life insurance, opportunities for education and employment, as well as in some cases financial loan eligibility. Because genomic-based research often occurs at the population levelâ€"as with genebanks and pharmacogenomics, for instanceâ€"obtaining authentic informed consent may be difficult, as it is not always clear what uses genetic material may be put to in the future, in light of unanticipated technological developments. All of this makes it imperative that health care providers and genetic counsellors be carefully trained, in order that they can provide appropriate information, guidance and support to patients and their families. These issues, among other, are addressed in greater detail in the section of this web-site that addresses the ethical, legal and social implications ELSI of human genomics. Education, policy and protecting basic rights Assuring that the rights of patients are protected requires more than educating policy makers and health providers; it requires educating citizens about what they should expect from their governments and their health care providersâ€"about the kind of treatment and respect they are owed. Citizens, then, can have an important part to play in elevating the standard of care when their own expectations of that care are raised. Some countries have recognized this, and have advanced their knowledge of genomics in public, academic and scientific spheres. Some follow democratic procedures to vote on resolutions pertaining to genomics. This knowledge and active engagement empowers lay individuals to make informed decisions about the future of genomics, both at the personal and at the policy level. Switzerland is the only country that has made a vote on genetic engineering in the future, with nearly two-thirds of its population voting against a referendum to ban

genetic engineering. Countries that have not made an active effort to educate and inform the public on the implications of genomics impede the development of policies and legislation that can protect patient rights by ensuring the appropriate development and application of genomic-based tools and genetic interventions. The creation of effective patient protection laws relies on public knowledge of genetic science and its applications, along with an awareness of the ethical, social, and legal issues surrounding genomics. Raising awareness of genomics and genetic services and technologies among the general public and patient populations can lead to fruitful advancement of genomics for broad health benefits. Member States are also encouraged to facilitate a two-way dialogue between the public and policy makers in order to guide the future development of ethical and regulatory systems of clinical practice. In light of the present need for increased awareness of human rights as they relate to health, and to patient rights more particularly, this section provides information on the rights of patients in various countries, including examples of exercised rights. Links to human rights organizations are also provided.

decision-maker has the same rights and responsibilities as a patient. UCSF health care providers will comply with these directives to the extent their existence is known and to the extent required by law.

If a group believes that a particular activity is "wrong" it can then use morality as the justification for attacking those who practice that activity. When people do this, they often see those who they regard as immoral as in some way less human or deserving of respect than themselves; sometimes with tragic consequences. Virtue Ethics is particularly concerned with the moral character of human beings. Searching for the source of right and wrong At times in the past some people thought that ethical problems could be solved in one of two ways: Philosophy can help identify the range of ethical methods, conversations and value systems that can be applied to a particular problem. But after these things have been made clear, each person must make their own individual decision as to what to do, and then react appropriately to the consequences. Are ethical statements objectively true? Do ethical statements provide information about anything other than human opinions and attitudes? Ethical realists think that human beings discover ethical truths that already have an independent existence. Ethical non-realists think that human beings invent ethical truths. The problem for ethical realists is that people follow many different ethical codes and moral beliefs. So if there are real ethical truths out there wherever! One form of ethical realism teaches that ethical properties exist independently of human beings, and that ethical statements give knowledge about the objective world. To put it another way; the ethical properties of the world and the things in it exist and remain the same, regardless of what people think or feel - or whether people think or feel about them at all. On the face of it, it [ethical realism] means the view that moral qualities such as wrongness, and likewise moral facts such as the fact that an act was wrong, exist in rerum natura, so that, if one says that a certain act was wrong, one is saying that there existed, somehow, somewhere, this quality of wrongness, and that it had to exist there if that act were to be wrong. Moral statements provide factual information about those truths. If a person says something is good or bad they are telling us about the positive or negative feelings that they have about that something. These statements are true if the person does hold the appropriate attitude or have the appropriate feelings. Emotivism Emotivism is the view that moral claims are no more than expressions of approval or disapproval. So when someone makes a moral judgement they show their feelings about something. Some theorists also suggest that in expressing a feeling the person gives an instruction to others about how to act towards the subject matter. Prescriptivism Prescriptivists think that ethical statements are instructions or recommendations. There is almost always a prescriptive element in any real-world ethical statement: Where does ethics come from? Philosophers have several answers to this question: God and religion a rational moral cost-benefit analysis of actions and their effects the example of good human beings a desire for the best for people in each unique situation political power God-based ethics - supernaturalism Supernaturalism makes ethics inseparable from religion. It teaches that the only source of moral rules is God. So, something is good because God says it is, and the way to lead a good life is to do what God wants. Intuitionists think that goodness or badness can be detected by adults - they say that human beings have an intuitive moral sense that enables them to detect real moral truths. They think that basic moral truths of what is good and bad are self-evident to a person who directs their mind towards moral issues. So good things are the things that a sensible person realises are good if they spend some time pondering the subject. Consequentialism This is the ethical theory that most non-religious people think they use every day. It bases morality on the consequences of human actions and not on the actions themselves. Consequentialism teaches that people should do whatever produces the greatest amount of good consequences. The most common forms of consequentialism are the various versions of utilitarianism, which favour actions that produce the greatest amount of happiness. Two problems with consequentialism are: It teaches that some acts are right or wrong in themselves, whatever the consequences, and people should act accordingly. Virtue ethics Virtue ethics looks at virtue or moral character, rather than at ethical duties and rules, or the consequences of actions - indeed some

philosophers of this school deny that there can be such things as universal ethical rules. Virtue ethics is particularly concerned with the way individuals live their lives, and less concerned in assessing particular actions. It develops the idea of good actions by looking at the way virtuous people express their inner goodness in the things that they do. To put it very simply, virtue ethics teaches that an action is right if and only if it is an action that a virtuous person would do in the same circumstances, and that a virtuous person is someone who has a particularly good character. Situation ethics Situation ethics rejects prescriptive rules and argues that individual ethical decisions should be made according to the unique situation. Rather than following rules the decision maker should follow a desire to seek the best for the people involved. There are no moral rules or rights - each case is unique and deserves a unique solution. Ethics and ideology Some philosophers teach that ethics is the codification of political ideology, and that the function of ethics is to state, enforce and preserve particular political beliefs. They usually go on to say that ethics is used by the dominant political elite as a tool to control everyone else. More cynical writers suggest that power elites enforce an ethical code on other people that helps them control those people, but do not apply this code to their own behaviour. Top Are there universal moral rules? One of the big questions in moral philosophy is whether or not there are unchanging moral rules that apply in all cultures and at all times. Moral absolutism Some people think there are such universal rules that apply to everyone. This sort of thinking is called moral absolutism. Moral absolutism argues that there are some moral rules that are always true, that these rules can be discovered and that these rules apply to everyone. Immoral acts - acts that break these moral rules - are wrong in themselves, regardless of the circumstances or the consequences of those acts. Absolutism takes a universal view of humanity - there is one set of rules for everyone - which enables the drafting of universal rules - such as the Declaration of Human Rights. Religious views of ethics tend to be absolutist. Why people disagree with moral absolutism: Therefore it makes sense to say that "good" refers to the things that a particular group of people approve of. They believe that relativism respects the diversity of human societies and responds to the different circumstances surrounding human acts. Why people disagree with moral relativism: Many of us feel that moral rules have more to them than the general agreement of a group of people - that morality is more than a super-charged form of etiquette Many of us think we can be good without conforming to all the rules of society Moral relativism has a problem with arguing against the majority view:

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Chapter 4 : Patient Rights and Responsibilities

For a case study that examines legal rights and ethical responsibilities with regard to medical care and informed consent, read Patient Autonomy & Informed Consent. Terms defined in our ethics glossary that are related to the video and case studies include: diffusion of responsibility, ethics, integrity, justice, morals, self-serving bias.

November revised Statement of the Issue Healthcare is among the most personal services rendered in our society; yet to deliver this care, scores of personnel must have access to intimate patient information. In order to receive appropriate care, patients must feel free to reveal personal information. In return, the healthcare provider must treat patient information confidentially and protect its security. All that being said, health care requires immediate access with information required to deliver appropriate, safe and effective patient care. All providers must be ever-vigilant to balance the need for privacy. Maintaining confidentiality is becoming more difficult. While information technology can improve the quality of care by enabling the instant retrieval and access of information through various means, including mobile devices, and the more rapid exchange of medical information by a greater number of people who can contribute to the care and treatment of a patient, it also can increase the risk of unauthorized use, access and disclosure of confidential patient information. Within healthcare organizations, personal information contained in medical records now is reviewed not only by physicians and nurses but also by professionals in many clinical and administrative support areas. It is imperative that all readers consult their own state patient privacy law to assure their compliance with their own law, as ACHE does not intend to provide specific legal guidance involving any state legislation. When consulting their own state law it is also important that all providers confirm state licensing laws, Joint Commission Rules, accreditation standards, and other authority attaching to patient records. All of these will be referred to collectively as "State Law" for the remainder of this Policy Statement. Protected h ealth information PHI can be used or disclosed by covered entities and their business associates subject to required Business Associate Agreements in place for treatment, payment or healthcare operations activities and other limited purposes, and as a "permissive disclosure" as long as the patient has received a copy of the providers Notice of Privacy Practices, has signed acknowledgement of that Notice, the release does not involve Mental Health Records, and the disclosure is not otherwise prohibited under state law. All providers should be sure their Authorization form meets the multiple standards under HIPAA, as well as any pertinent state law. While media representatives also seek access to health information, particularly when a patient is a public figure or when treatment involves legal or public health issues, health care providers must protect the rights of individual patients and may only disclose limited directory information to the media. Healthcare executives must implement procedures and keep records to enable them to "account" for disclosures that require authorization as well as most disclosures that are for a purpose other than treatment, payment or health care operations activities. Patients have the right to request and receive an accounting of these accountable disclosures under HIPAA or relevant state law. While the healthcare organization possesses the health record, outside access to the information in that record must be in keeping with HIPAA and state law, acknowledging which disclosures fall out from Permissive Disclosures as defined above, and may require further patient involvement and decision making in the disclosure. Organizations therefore must determine the appropriateness of all requests for patient information under applicable federal and state law and act accordingly. In fulfilling their responsibilities, healthcare executives should seek to: Determine disclosures beyond the treatment team on a case-by-case basis, as determined by their inclusion under the Notice of Privacy Practices or as an Authorized Disclosure under the law. Ensure that institutional policies and practices with respect to confidentiality, security and release of information are consistent with regulations and laws. Educate healthcare personnel on confidentiality and data security requirements, take steps to ensure all healthcare personnel are aware of and understand their responsibilities to keep patient information confidential and secure, and impose sanctions for violations. Conduct periodic data security audits and risk assessments of

the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic data, at a frequency as required under HIPPA and related Federal legislation, State law, and HIT "Best Practices". Provide for appropriate disaster recovery, business continuity and data backup. Establish guidelines for "sanitizing records" masking multiple patient identifiers as defined under HIPAA so the patient may not be identified in committee minutes and other working documents in which the identity is not a permissible disclosure. Adopt a specialized process to further protect sensitive information such as psychiatric records, HIV status, genetic testing information, sexually transmitted disease information or substance abuse treatment records under "Authorization" as defined by HIPAA and State law. Obtain Business Associate Agreements with any third party that must have access to patient information to do their job, that are not employees or already covered under the law, and further detail the obligations of confidentiality and security for individuals, third parties and agencies that receive medical records information, unless the circumstances warrant an exception. Appropriately complete Business Associate Agreements, including due diligence on third parties who will receive medical records information and other personal information, including a review of policies and procedures appropriate to the type of information they will possess. Ensure where applicable that such third parties adhere to the same terms and restrictions regarding PHI and other personal information as are applicable to the organization. Update all Business Associate Agreements annually. Follow all applicable policies and procedures regarding privacy of patient information even if information is in the public domain. Review applicable state and federal law related to the specific requirements for breaches involving PHI or other types of personal information. In the event of a security breach, conduct a timely and thorough investigation and notify patients promptly and within the timeframes required under applicable state or federal law if appropriate to mitigate harm, in accordance with applicable law. Establish adequate policies and procedures to mitigate the harm caused by the unauthorized use, access or disclosure of health information to the extent required by state or federal law. Participate in the public dialogue on confidentiality issues such as employer use of healthcare information, public health reporting, and appropriate uses and disclosures of information in health information exchanges.

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Chapter 5 : MEDICAL LAWS & ETHICS IN INDIA

Patient responsibilities include those actions on the part of patients that are needed so that healthcare providers can provide appropriate care, make accurate and responsible care decisions, address patients' needs, and maintain a sound and viable health care facility.

Adam Sonfield ,Guttmacher Institute First published online: August 1, The U. The Values at Stake Although different associations and professions frame the issues differently, core values that are generally agreed upon across health care professions and in the field of bioethics underlie the rights and the responsibilities of all health care providers: These core values have been translated into more specific ethical principles by numerous professional associations. Such guidelines are necessary in part because these values can at times conflict or appear to point in different directions. In the absence of respect for autonomy, for instance, beneficence can easily turn into paternalism in the hands of a highly trained health care provider caring for patients with inferior knowledge. And, while the International Code of Medical Ethics of the World Medical Association WMA asserts that "a physician shall always bear in mind the obligation of preserving human life," in a separate declaration on abortion, the WMA discusses how the "diversity of attitudes towards the life of the unborn child" can lead to differences in how to interpret this obligation. Professional standards help to mediate these differences. Despite the complexities of balancing these values, the professional medical associations have been remarkably consistent when it comes to the concept of refusal. At the same time, these standards make clear that there must be limits to this right in order to ensure that patients receive the information, services and dignity to which they are entitled see box , page 8. It should come as no surprise that many of the most detailed standards and policy statements about refusal focus on abortion, contraception and other forms of reproductive health care, along with end-of-life care. These services have often generated controversy among policymakers and the general public. The professional associations have made their position clear, however: Responsibility and Reality Public policy, however, has not always matched up with the principles endorsed by professional medical associations, and the situation appears to be getting worse. Within weeks of the U. The Church Amendment prevents the government as a condition of a federal grant from requiring health care providers or institutions to perform or assist in abortion or sterilization procedures against their moral or religious convictions. It also prevents institutions receiving certain federal funds from taking action against personnel because of their participation, nonparticipation or beliefs about abortion or sterilization. The question is not specifically addressed, but nothing in this policy suggests that anyone has the right to withhold information from a patient or refuse to refer a patient to another provider. Almost every state in the country also has decades-old policies allowing individual health care providers to refuse to participate in abortion; many of these laws also apply to sterilization, and in 10 states, to contraception more broadly. These laws often depart more explicitly than the Church Amendment from the professional standards discussed above: The architects of more recent legislation in many cases appear to have purposefully blurred or actually crossed the line between a right to withdraw and a right to obstruct. One subtle example of this was a provision included in legislation that created national standards for Medicaid managed care, including the standard that plans could not "gag" providers from telling Medicaid patients about treatment options not covered by the plan. Yet, Congress also allowed plans to refuse to cover counseling and referral activities to which they object on religious or moral grounds, creating a financial barrier to obtaining informed consent and ensuring access to care. Another obstructionist provision, named after its sponsor, Rep. Dave Weldon R-FL , was passed in as part of an annual appropriations law. It forbids federal, state and local governments from requiring any individual or institutional provider or payer to perform, provide, refer for, or pay for an abortion. A law passed in Mississippi in may be the best example of the expansive new breed of refusal clause. It allows almost anyone connected with the health care industryâ€”from doctors, nurses and pharmacists to the clerical staff of hospitals, nursing homes and drug storesâ€”to refuse to participate or assist in any type of health care

service, including referral and counseling, without liability or consequence. In the process, it violates every one of the obligations to patients and employers listed above around information, referral, emergencies, notice and the like. A poll of U. Rather, many observers have focused on cases where pharmacists have refused to transfer a prescription or refer a client to another pharmacist and where they have made oftentimes hostile attempts to dissuade women from using the product. Some advocates for expansive refusal rights have argued that such actions are justified and should be protected. They assert, for example, that a pharmacist who refers a woman to someone else to fill her prescription for contraception is just as guilty as if the pharmacist filled the prescription himself. Such extremist behavior appears to be fueling a backlash. Policies adopted this year in Illinois and Nevada and introduced in at least five other states and in Congress would ensure that patients have access to legally prescribed medications, often by requiring a pharmacy to meet this need even if an individual pharmacist it employs refuses see related story , page The AMA responded to the pharmacist controversy in June by adopting a resolution supporting legislation to ensure that pharmacists and pharmacies either fill valid prescriptions or "provide immediate referral to an appropriate alternative dispensing pharmacy without interference. It sounds reasonable that a pharmacy ensure that every prescription is filled, even if an individual pharmacist refuses, but this can be difficult in pharmacies where only one pharmacist is on duty at a time. Perhaps requiring referral to another pharmacy is an answer, but is that pharmacy close enough? Does it have the drug in stock? Will the pharmacist there refuse as well? And what impact will that have on the original pharmacy in terms of customers lost? Such concerns have led to even more creative proposals. The AMA, for example, has called for legislation allowing doctors to dispense medication when no pharmacist within 30 miles is "able and willing" to do the job. Lawmakers, likewise, have addressed some of these details in crafting their proposals. Ultimately, no policy may be able to address every contingency, however. In such cases, professional standards are there to provide guidance, and to remind everyone that responsibility to the patient must always be the top priority and that a right to withdraw must never be turned into a right to obstruct. The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice. If personal moral, religious, or ethical beliefs prevent a PA from offering the full range of treatments available or care the patient desires, the PA has an ethical duty to refer an established patient to another qualified provider. PAs are obligated to care for patients in emergency situations and to responsibly transfer established patients if they cannot care for them. Pharmacists and their employers will need to develop processes that support the decision of the individual pharmacist while still providing the appropriate services the patient seeks. Should a pediatrician choose not to counsel the adolescent patient about sexual matters such as pregnancy and abortion, the patient should be referred to other experienced professionals. Nurses have the professional responsibility to provide high quality, impartial nursing care to all patients in emergency situations The conclusions and opinions expressed in this article, however, are those of the author and the Guttmacher Institute.

Chapter 6 : Ethical Policy Statement: Health Information Confidentiality

The rights and responsibilities listed below do not establish legal entitlements or new standards of care, but are simply intended to guide you through the development of a successful and collaborative dentist-patient relationship.

To assure that the basic rights of human beings for independence of expression, decision and action, concern for personal dignity and human relationships are preserved for all patients, and to define the responsibilities of patients seen at University Health Conway Policy: It is the policy of University Health to respect the individual rights of all persons that come to this facility for care. Patient rights include the right to make decisions regarding medical care, the right to accept or refuse treatment, and the right to formulate advance directives written instructions, such as a living will or durable power of attorney for health care as recognized under Louisiana state law, relating to the provision of such, when an individual is incapacitated. Access to Care Individuals shall be afforded impartial access to treatment that is available and medically indicated, regardless of race, creed, sex, national origin, religion, sexual orientation, disability or source of payment. Free translation services are available. Respect and Dignity The patient has the right to considerate, respectful care at all times, under all circumstances, with recognition of his personal dignity and worth. Privacy and Confidentiality The patient has the right, within the law, to personal privacy and information privacy, as manifested by the right to: Refuse to talk with or see anyone not officially connected with the hospital, including visitors, persons officially connected with the hospital but who are not directly involved in his care. Wear appropriate personal clothing and religious or other symbolic items, as long as they do not jeopardize safety or interfere with diagnostic procedures or treatment. To be interviewed and examined in surroundings designed to assure reasonable audiovisual privacy. Expect that all communications and other records pertaining to his care, including the source of payment for treatment, be treated as confidential. Expect that information given to concerned family members or significant other legally qualified person, be delivered in privacy and with due consideration of confidentiality. Request transfer to another available room if another patient or visitors in that room are unreasonably disturbing to said patient. Personal Safety and Security The patient has the right to expect reasonable safety in so far as the hospital practices and environment are concerned. To address the needs of patient, visitor and staff regarding safety and security, the University Police patrol 24 hours per day and are present in the Emergency Room around the clock. Other safety and security measures include limited access to the facility through the use of electronic access cards and readers on exterior entrances, video monitoring in numerous areas of the campus, and the use of employee identification badges that are to be conspicuously displayed. Identity The patient has the right to know the identity and professional status of individuals providing service and which physician or other practitioner is primarily responsible for his care. Participation by patients in research programs, or in the gathering of data for research purposes, shall be voluntary with a signed informed consent. Information The patient has the right to obtain from the practitioner responsible for coordinating his care, complete and current information concerning his diagnosis to the degree known , treatment, pain management, and any known prognosis. This information should be communicated in terms the patient can reasonably be expected to understand. When it is not medically advisable to give such information to the patient, the information shall be made available to a legally authorized individual. The patient has the right to formally access his medical records. The patient shall complete the Authorization to Disclose Protected Health Information form which is then sent to Health Information Management for processing. Communication The patient has the right of access to people outside the hospital by means of visitors, and by oral and written communication. The patient may request not to be included in the patient directory. The prisoner patient has the right to visitors only as approved by the warden of the prison or jail where the prisoner patient is incarcerated. This is particularly true where language barriers are a continuing problem. Where medically significant alternatives for care or treatment exist, the patient shall be so informed. The patient has the right to know who is responsible for authorizing and performing the

procedures or treatment. The patient may refuse treatment to the extent permitted by law. If a patient is unconscious or is determined to be mentally incompetent and no consent can be obtained from an appropriate family member, legal action may be taken to obtain a court order for diagnostic and therapeutic procedures. In life-threatening emergencies, where the patient is incompetent or unconscious, appropriate treatment may be administered without consent. The patient shall be informed of eligibility for reimbursement by any third-party coverage during the admission or pre-admission financial investigation. Complaint Process The patient has the right to file a complaint regarding services and is entitled to information regarding the hospitals mechanism for the initiation, review and resolution of such complaints. Patient Responsibilities Patients have the responsibility for: Providing accurate and complete information about medical complaints, past illnesses, hospitalizations, medications, pain, and other matters relating to their health. Following the treatment plan recommended by those responsible for their care. Seeing that their bills are paid as promptly as possible; following hospital rules and regulations. Being considerate of the rights of other patients and hospital personnel. Seeking information, and in the event they have questions, asking them.

Chapter 7 : Informed Consent: An Ethical Obligation or Legal Compulsion?

The role and responsibility of the nurse as well as the rights of patients are supported within law, and within the ethical framework provided by the American Nurses Association Code of Ethics for Nurses with Interpretive Statements (ANA,).

Chapter 8 : BBC - Ethics - Introduction to ethics: Ethics: a general introduction

ETHICAL ANGLE. The concept of consent arises from the ethical principle of patient autonomy[] and basic human rights.[] Patient's has all the freedom to decide what should or should not happen to his/her body and to gather information before undergoing a test/procedure/surgery.

Chapter 9 : WHO | Patients' rights

The Patient Self-Determination Act (PSDA) is a federal law, and compliance is mandatory. It is the purpose of this act to ensure that a patient's right to self-determination in health care decisions be communicated and protected.