AARC 2014 Law and Professional Ethics Course narrative script

Module 1: Components of Ethical Problems

Introduction
Welcome to the AARC's ethics course. The purpose of the course is to help the California respiratory care practitioner recognize and understand important ethical challenges. This course will begin by familiarizing the respiratory therapist with ethical problems and steps necessary for ethical decision-making followed by modules covering informed consent and advance directives; confidentiality and truth; professionalism and scope of practice; continuing education; conflict of interest; illegal and unethical acts; ethics of biomedical research; and California law. This course will meet the Respiratory Care Board of California's law and professional ethics course requirements.

Section I: Morality or ethics
Morality and ethics are terms that are often used interchangeably. However, there are distinct differences between the two. Morality is the term used to describe shared beliefs about right and wrong conduct in a culture or society while ethics is the term used to describe the discipline that studies and provides an analysis of morality. A person's morality is composed of their values (what they hold dear), their duties (required actions), and their character (traits that would describe someone as "moral").

There are three different subsets of morality: personal morality, societal morality, and group morality. Personal morality is just that; a person's own morality based on his/her values, experiences and beliefs. Societal morality is that shared morality held by society at large. This is developed with common values and beliefs. It's not uncommon for individuals to not completely agree with societal morality. Group morality is that held by a certain group, such as respiratory therapists, nurses, sororities, and church congregations, to name a few. This morality is also developed with common values, beliefs, and goals within the context of the group purpose. As with societal morality, an individual may not completely agree with the group morality.[1]

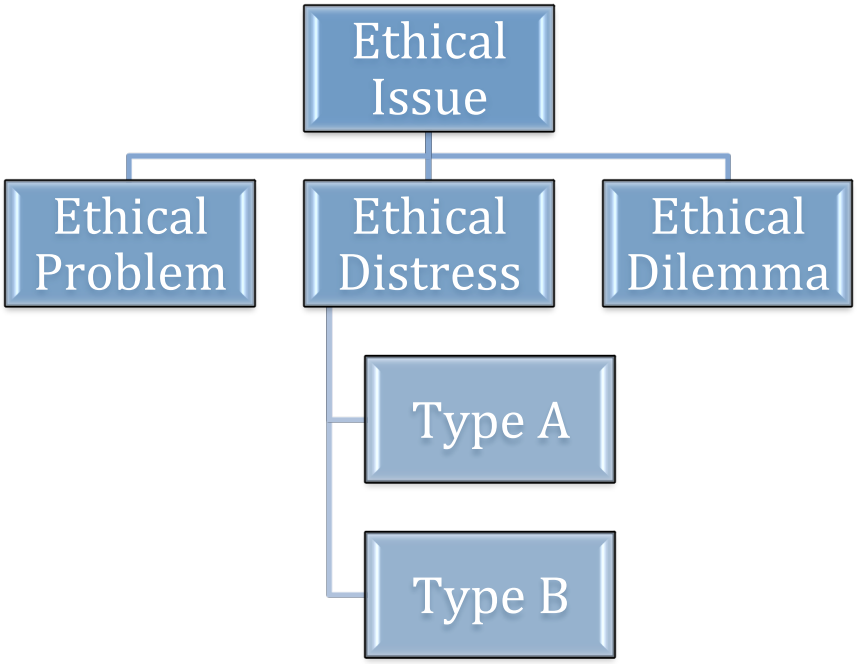
Note that morality is identified by shared beliefs-this means that the majority of the societal group accepts certain behaviors and rejects others. This means that ethics and law are not interchangeable. The law is the minimum acceptable behavior standard set by society to protect the public. Ethically supported behaviors are those that conform to a higher standard. For example, homicide is illegal and accepted by the majority of American society as an immoral act. However, cheating on a spouse is not an illegal act. Is it an immoral or unethical act? It depends on your perspective. It is important to remember that ethics is the analysis of these acts, not how we feel or believe.

Upon occasion, ethics may be confused with religion. It is important to remember that, while religion does play a large part in the formation of our personal morality as well as serve as the basis for many societal and group moralities, ethics and religion are not interchangeable. In this program, we'll use critical thinking skills to identify and analyze ethical situations in the context of the respiratory care professional and health care.

Section II: Ethical Issues

Ethicists categorize ethical scenarios in such a way as to identify the root cause and analyze the situation. Using these categories, we can identify common situations in healthcare we may experience. These categories include ethical issues, ethical problems, ethical distress and ethical dilemmas.

An ethical issue is just that: an issue that may have ethical consequences. Not all of the consequences are negative. Some common ethical issues in healthcare include decisional capacity, allocation of resources, and prolonging life.

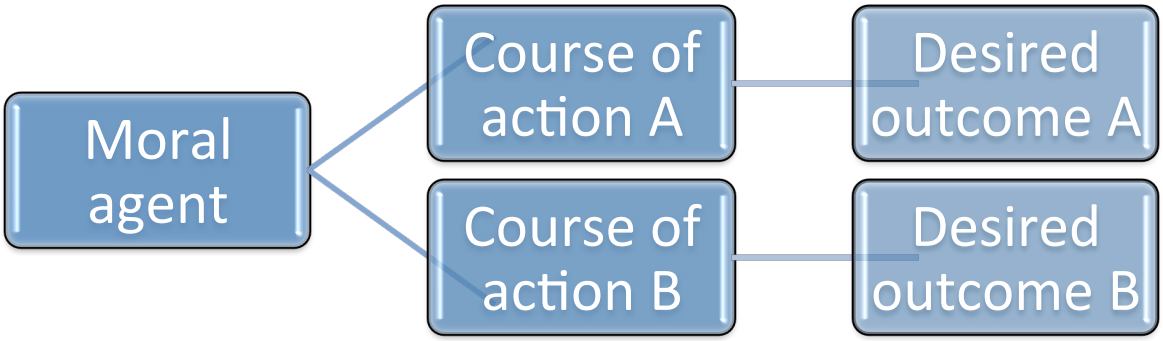


An ethical situation that may have serious negative implications regarding moral values and duties is identified as an ethical problem. There are three components of ethical problems: the moral agent, a course of action, and a desired outcome. The moral agent is someone who acts for him/herself while also trying to conform to a standard of behavior. The course of action includes the moral agent's analysis of the situation, his/her judgment process and the decision at which the moral agent arrives. The desired outcome is the intended result of the course of action

Without clear direction, a course of action cannot be effective. Therefore, the moral agent must identify the desired outcome prior to initiating the course of action. Let's look at an example of an ethical problem and how the moral agent can determine an effective course of action to achieve the desired outcome. In health care, the desired outcome should take into account not only the protection of the health care professional but also the protection of the patient, hospital, and community.

Ethical distress describes a situation in which the moral agent knows the right thing to do but there is something preventing the action. There are two prototypes of ethical distress: Type A and Type B. A Type A ethical distress occurs when the moral agent understands the barrier that prevents him/her from completing the ethically supported course of action. For example, the respiratory therapist knows that her colleague is taking supplies from the ICU supply cart for her personal use. The respiratory therapist knows that this is wrong but, due to peer pressure from others and wanting to keep her colleague's friendship, she is prevented from notifying her direct supervisor. Other barriers in Type A ethical distress situations include prohibitive policies and procedures; financial restraints, personal feelings or biases; and anxiety or fear. A Type B ethical distress occurs when the desired outcome can be identified but the moral agent is having a difficult time identifying the barrier and, therefore, a clear course of action. A new situation, one that has not previously been experienced by the health care team, or an extremely complex situation causing ethical distress may be classified as a Type B distress.[1]

An ethical dilemma involves two or more ethically supported courses of action. However, the moral agent cannot take both routes. Choosing one ethically supported path over the other results in negative consequences. For example, two patients have been admitted to the emergency department and are in dire need of a pint of blood. Only one pint of blood is available. Transfusing Patient A with the pint of blood promotes a positive consequence but it automatically deprives Patient B from receiving the benefit of the transfusion and therefore promotes a negative consequence. It should be noted that an ethical dilemma might have many potential courses of action that can lead to many different outcomes. Critically thinking through the options to determine the most ethically supported potential course of action and desired outcome is essential.



Module 2: Ethical Decision-Making

Introduction

Now that we're able to distinguish between various ethical situations, we can work through the situation and arrive at that desired outcome. However, there are a great many factors that will impact how we identify the desired outcome and what course of action is most ethically supported. In this module, we will develop an understanding of ethical theories that can help us analyze ethical challenges and learn about a decision-making model that may make it easier to arrive at that desired outcome.

Section I: Ethical Theories

There are many ethical theories that have been used to analyze ethical challenges in healthcare. These theories can be grouped together in broad categories but the commonly used theories fall into these categories: deontological, or duty-based, theories; teleological, or consequence-based theories; virtue or character-based ethics; ethics of care; and the principle-based approach.

The deontological theories are sometimes referred to as duty ethics. Immanuel Kant is a popular theorist in this category. The basic premise is that a person is acting rightly when he/she acts according to duties that are set forth. In other words, the ends do not justify the means; the outcome is not taken into account in this equation. A major criticism of these theories is that it is often in conflict with common sense morality and that it does not accommodate for the nuances of the situation.[1,2,3]

In contrast, the teleological theories focus on the consequences or outcomes and not the act itself. Jeremy Bentham and John Stuart Mill are theorists associated with the teleological theories. Utilitarianism and consequentialism are two examples of these theories. The basic tenant is that the act is ethically supported if it helps to bring about the best balance of benefits over burdens. The person who uses a teleological theory is driven by the goal itself, not the acts that are necessary to accomplish that goal. A major limitation of these theories is that it is difficult to accurately predict the potential benefits and the potential harm in order to find the right balance.[1,3]

Virtue ethics is a family of theories that focuses on character. These theories are commonly attributed to the Greek philosophers Plato and Aristotle. According to these theories, an act is morally right if it is one that a virtuous person, acting in character, would do in that situation. We can call these virtuous persons "moral exemplars" as they are to set an example for the rest of us. There are many criticisms of virtue ethics: it may not take into consideration tragic dilemmas; it may not offer adequate or clear moral guidance; it may be too demanding; and it is unclear as to the identity of these moral exemplars.[1,3]

The ethic of care is also called feminist ethics, though feminism is more of a general approach, not a theory of ethics. Posited by Carol Gilligan, this theory focuses on relationships and the interdependence of all individuals for achieving their interests. Specifically, the theory defines the importance of emotions, is against one supreme rule, is against impartiality and abstraction, is against competition, and downplays rights or the

theory of justice. Among the many criticisms is that justice and rights are still a very important part of morality and lack of consideration of those rights may result in lack of moral protection.[1,3]

The principle-based approach, also called principles of medical ethics, is a common method of evaluating issues in health care situations. Some sources use eight principles[2] while other sources[4] focus on four main principles: autonomy, justice, non-maleficence, and beneficence. The principle of autonomy describes a person's ability to make decisions for him or herself. This can be expressed in professional autonomy, as the health care provider acts within the scope of care in his/her profession; in patient autonomy, as the patient makes health care decisions based on available information; or in social autonomy, as the citizen acts within the scope of society.[1] Justice is defined as "fair, equitable, and appropriate treatment in light of what is due or owed to persons."[4] Therefore, justice in health care is about distributing benefits and burdens among patients and health care providers. Non-maleficence and beneficence reflect similar aspects in healthcare. Non-maleficence is the concept that we avoid actively harming someone. Beneficence, on the other hand, means that we actively benefit someone. We do this by preventing harm, removing harm when it is inflicted, and bringing about a positive good to that person. The main criticism of the principle-based approach is that there is no guidance to determine which principle has the highest value.[1,4]

Of special note is the concept of double effect. Some criticize this as an ethical loophole. To qualify for double effect (which would label the action as "ethically supported"), an action has to meet four criteria:

1. The act must be good or at least morally neutral;
2. The moral agent must intend only the good effect;
3. The bad effect must not be the means of bringing the good effect; and
4. The good and bad effects must be proportional[4]

Let's look at it in context with a case.

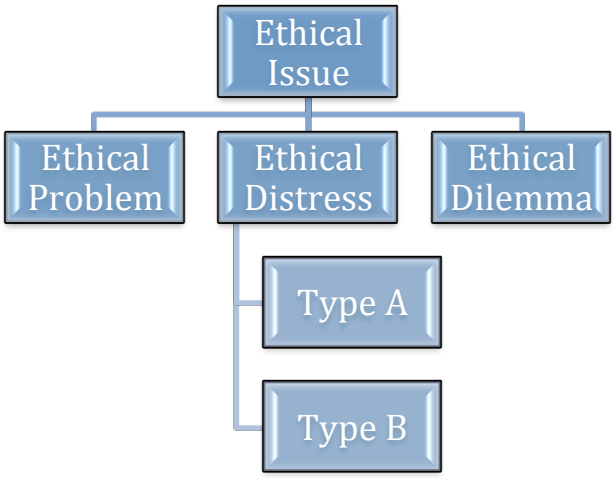
Section II: Ethical Decision-Making

Several authors have developed decision-making models to help with these issues. In this program, we will use the 6 Step Process to Ethical Decision-Making, developed by Purtilo and Dougherty.[1] Note that the specific model to decision-making is less important than utilizing an objective, comprehensive review of the situation prior to making judgments and deciding upon a course of action. As we learn about the 6 Step Process, we'll apply it to a case for better understanding.

#1 Get the facts! The first step in the decision-making process is to gather all relevant information about the given situation. In Sarah's case, there are many facts that will contribute to the desired outcome and course of action. First, Sarah is homeless. This means that she has minimal finances; likely no insurance; minimal, if any, prior health care; minimal access to health care; and lack of proper nutrition. These issues have both present and future impact on Sarah's health. Secondly, she has been admitted for potential tuberculosis, which is highly probable given her risk factors and physical presentation. Due

to this potential diagnosis, she has been quarantined for the protection of others in the hospital: other patients, health care providers, non-clinical hospital employees, and visitors. At this point, she has refused to comply with public health policy and remain in her room. Another important fact is that the activity in which she wishes to engage is harmful to her health even if she does not have a potentially life threatening lung disease. What other questions might you have regarding this case? It is important to note that, in many situations, there may be facts that impact the case that are not readily apparent.

#2 Identify the problem. The second step is to identify the problem at hand. In module 1, we discussed the differences between ethical problems, ethical dilemmas and ethical distress. Kyle finds himself in an ethical distress situation. He knows that it is most beneficial for the whole hospital for Sarah to follow health care policy and stay in her hospital room so that the potential spread of tuberculosis is contained. He also knows that smoking cigarettes will have a negative health consequence for Sarah. However, Sarah does not wish to stay in her room.



#3 Use ethical theories to analyze the problem. The third step is to use ethical theories to analyze the problem. There are many ethical theories at our disposal to analyze this situation. As we consider our case, we note that our entire ethical balance may shift from honoring the individual to protecting the community.

We could use the teleological theories to analyze this problem. Remember that these theories state that right and wrong depend only upon the foreseeable consequences of the action. We can foresee that, if Sarah does indeed have tuberculosis, other persons acquiring the airborne illness and perhaps spreading it to others in the community. From this theory, the most ethically supported act is to confine Sarah to her hospital room.

The problem with applying teleological theories is that we are looking at this situation from one perspective: that of the public. We do not account for Sarah's perspective at all when considering the greater good or the future consequences. The principles-based approach, however, allows us to explore Sarah's situation from multiple perspectives. Using this approach shows us that beneficence, non-maleficence, autonomy, and justice can be used to evaluate this case.

- Beneficence: The health care team is trying to protect other patients, which promotes beneficence. Sarah's "good" is hard to determine, other than doing what she wants, when she wants to. The cigarette smoking certainly doesn't promote good health but the social and psychological impact of smoking may provide her with personal good.
- Non-maleficence: In the case of transmitting tuberculosis, significant harm is presented to others-potential exposure to a highly drug resistant disease-while risk to Sarah is limited to the negative effects of the smoking and harm to her ability to interact with others in a social setting.
- Autonomy: Sarah does have the right to make her own decisions but does it allow her to make those decisions that harm others? Many would say no; my autonomy ends where yours begins. She's putting a large, vulnerable population at risk. On the other hand, constraining Sarah to her hospital room does strip her of her autonomous right and may be viewed as false imprisonment.
- Justice: the physicians are limiting Sarah's freedoms and rights to protect others. Therefore, Sarah is not treated in the same fashion as others are treated.

#4 Explore practical alternatives: The fourth step is to explore practical alternatives. The key word in this step is "practical." What are some potential courses of action, based on our previous ethical analysis? This is the time to brainstorm all possible options and then debate the benefits and disadvantages to each option. Ultimately, the goal is to find the most ethically supported option to produce our desired outcome.

Option #1: Let Sarah do what she wants. Advantages to this approach include honoring Sarah's autonomy. The disadvantages include infecting the rest of the hospital, which would violate the principles of beneficence, and non-maleficence.

Option #2: Post a guard outside Sarah's hospital door. The advantage of this option is that the rest of the hospital (patients, visitors, staff) is protected, which upholds the principles of beneficence and non-maleficence to all stakeholders. By constraining Sarah to her room, she won't suffer the negative effects of the smoking. However, this completely overrides Sarah's autonomous rights as an individual and she will suffer the effects of nicotine depravation.

Option #3: Provide Sarah with a sitter and/or escort. This would allow Sarah to exert her autonomous right to leave her room while wearing an approved mask. However, actively encouraging her smoking habit would be harmful to her overall health. This is also costly to the hospital, as it would have to pay for the sitters/escorts to simply be with Sarah one-on-one for 24 hours a day. This allocation of hospital resources would potentially take away patient care from others, which would violate the justice principle.

Option #4: Constrain Sarah to her room and provide Sarah with smoking cessation aids and educational sessions. This might promote overall health benefits, upholding the beneficence and non-maleficence principles though it still overrides her autonomy.

#5 Complete the action. The fifth step is to make a decision to move toward achieving the desired outcomes. At this point, we need to consider the clinical options we previously identified and decide which one is optimal for this patient in this situation.

#6 Evaluate. After the scenario has been resolved, we need to review the case and the outcome. Did our intervention work? Did we achieve the desired outcomes? This step is vital to ensuring future situations similar to Sarah's are handled appropriately. Could a policy change prevent this issue in the future? Are the processes of the hospital appropriate or does the administration of the hospital need to evaluate the processes more carefully to avoid potential problems? Applying lessons learned from past experiences can help improve policies, procedures, processes and responses to many difficult situations.

Module 3: Informed Consent and Advance Directives

Introduction

The phrase "informed consent" is sometimes used to describe a signed document that allows health care providers to perform surgical procedures, diagnostic tests, and some therapies. However, true informed consent is a process, not a document. In this module, we will discuss matters that are involved in honoring a patient's autonomy to direct his/her health care, including informed consent and advance directives.

Section I: Decisional capacity

When a patient is admitted to a health care facility, he/she is asked to provide consent to a variety of tests and/or procedures. Before we accept the patient's acceptance, we tend to ask if the patient is competent. By competent, we mean that the patient is able to cognitively understand the risks and benefits of the procedure or test offered, is able to communicate his/her choices to the health care team, and is making decisions that are consistent with his/her own personal values.[5] If a person is able to meet all of these requirements, then they have met criteria for decisional capacity.

Decisional capacity, also referred to as decision-making capacity, may be compromised in times of illness or poor health. These situations may be anticipated or unexpected. Examples where a person may anticipate the loss of decisional capacity include early stage Alzheimer's disease and patients undergoing surgery. There is a reasonable expectation that, under the influence of the disease or sedation, the patient will not be able to comprehend the medical issues nor will the patient be able to make health care decisions for him/herself.[5]

Decisional capacity may also be compromised by coercion. Some sources of coercion are avoidable while others are not. For example, family members with strong opinions or the biased discussion of treatment options with a physician could influence a patient's health care decision. Another source of coercion is fear of the disease, treatment, or procedure. Discussing his recent lung transplantation procedure, a cystic fibrosis patient told a group, "I remember reading these forms [informed consent] and realizing that they were going to cut me open and remove two of my vital organs and put someone else's in and I was supposed to say that was ok." The patient consented to the procedure because this was the only long-term treatment option for his declining lung function, not because he truly desired the experience of open thoracic surgery and the risks involved.

Decisional capacity is a determination made by a physician who interviews the patient in the context of the health care setting. Some physicians use mental status testing to assess decisional capacity. This may involve evaluation of a patient's orientation, attention span, recall abilities, short-term memory, long-term memory, and language skill. However, many physicians directly assess the patient's decisional capacity by engaging him/her in a discussion of the disease, treatment options, risks and benefits of treatment options, and alternatives to the offered treatment. Some practitioners will request the assistance of a psychiatrist. Most find this helpful in situations where the decisional capacity of the patient is questionable.[5]

There are instances when a patient lacks decisional capacity. Some physicians use the phrase "incompetent to make decisions." As mentioned previously, this could be caused by a pathologic state that impairs cognition or a temporary state of sedation. Persons under the age of 18 years are automatically considered incompetent. In these cases, a surrogate such as a parent or legal guardian makes health care decisions.

The purpose of a surrogate decision maker is to provide a substitute who can make healthcare related decisions on behalf of the patient who lacks decisional capacity. Ideally, the surrogate should be able to make healthcare decisions that reflect the values of the patient. This helps provide direction to the health care team as they determine what treatment options are available to the patient. Typically, the next of kin or a close friend is identified to be the surrogate. In the absence of family or friends, a court appointed guardian might be substituted.

Problems may arise when using substituted judgment for healthcare decisions. One problem is that the surrogate may not make decisions that are reflective of the patient's values. The patient may have been very vocal about not wanting long-term mechanical ventilation prior to the injury that left him without decisional capacity, but his father demands continued life-saving measures. Another issue that is common is disagreement among family members. The primary surrogate may be hesitant to make a decision because of the disagreement with the other family members. Family members might also have a conflict of interest. These situations usually occur when there is a large inheritance involved.

An issue that many health care providers tend to forget is that the family of the critically ill patient is under a great deal of emotional stress. Their loved one has been seriously injured or suffered a major health crisis. The health care team then asks the surrogate decision-maker to remain calm, process complicated medical information, and arrive at a logical conclusion while also dealing with the powerful emotions accompanying the situation. In these situations, a social worker or person of the clergy may be helpful to the surrogate.

Section II: Informed consent

When a patient is faced with health care choices, he/she must be truly informed about a great number of aspects regarding those choices. We call this "informed consent." With the informed consent process, the patient must be provided with enough information to allow them to make a truly informed decision and either reject or accept the options offered. That information includes the nature and purpose of the offered intervention, any known alternative to the offered intervention, consequences of refusing the offered intervention, what the offered intervention involves, the expected results of the offered intervention, any risks involved with the intervention, and the most frequently experienced side effects from others who have endured the offered intervention. Informed consent must be obtained, either from the patient or the surrogate decision-maker, when there is enough time to weigh the options.

Upon occasion, physicians can assume that the patient would consent to the intervention. This is called "implied consent." These situations must be life threatening or pose a risk of significant physical injury if the intervention is not performed. Even in this case, only the procedures that are absolutely necessary can be performed. Let's explore a situation that demonstrates this concept.

It is important to remember that a competent patient can make an irrational decision. In many instances, health care providers do not question the decisional capacity of a patient who agrees with the health care team. Indeed, the decisional capacity of the patient is usually questioned when the patient disagrees with the team. If the patient truly understands the situation and the consequences of refusing the offered treatment or procedure, then he/she can assert autonomy and refuse the treatment. In a real-life case, a 77-year-old woman diagnosed with gangrene of the right foot refused amputation of her leg. The courts found her to have decisional capacity and, though her decision is unfortunate and perhaps irrational, upheld her autonomous right to refuse the amputation.[6]

While this situation doesn't involve respiratory therapists, it does demonstrate how the legal system may get involved in a disagreement about competency. Many of us have worked with patients and families who continued life support when the health care team recommended against it or refused life saving measures offered by the team.

Section III: Advance directives

An advance directive is a legal document that provides information about the patient's health care preferences, should the patient lose decisional capacity and is unable to give or withhold consent for diagnostic or therapeutic procedures. The US Patient Self-Determination Act of 1990 mandates that every patient admitted to a health care institution is asked, upon admission, whether he or she has an advance directive or would like to prepare one. There are three types of directives: living wills, durable power of attorney (DPOA) and do not attempt resuscitation (DNAR).

A living will is a document written by the patient, usually with the help of an attorney, before he/she loses decisional capacity. Living wills are typically written when a person can foresee a time in the future when he/she may not be able to make health care decisions. For example, a patient diagnosed with ALS or Alzheimer's disease may wish to take a pro-active approach to her future health care. The living will states that, if the patient should become incompetent and have a terminal illness, she would like or not like to receive the listed health care treatments. The challenge to a living will is that the patient is attempting to make decisions on a future that is not clear. Health care providers find it difficult, upon occasion, to interpret the document in the context of the specific patient situation.

A durable power of attorney (DPOA) is also a document written by the patient prior to losing decisional capacity. Similar to the living will, it addresses a foreseeable future where the patient is unable to make health care decisions. With this document, the patient appoints a trusted person to make health care decisions for the patient in his/her best

interest. The person appointed should be aware of the patient's health care preferences in a multitude of situations. Again, a limitation of this document is the lack of information provided to the surrogate decision maker holding the DPOA.

The do not attempt resuscitation (DNAR) document is a physician's order in the medical chart. Ideally, the physician writes this document with input from the patient, surrogate decision maker and other stakeholders. The document specifies which treatments are to be attempted and which are not. The document has moved from the "do not resuscitate" to "do not attempt resuscitation" wording to address the implied success of cardiopulmonary resuscitation (CPR). Family members and patients had an unrealistic expectation that all treatments attempted would be successful when the reality is that about 15-20% of witnessed cardiac arrests with in-hospital CPR attempts survive to discharge.[7]

Again, the challenge to all of these documents is that they attempt to address a future that is unclear. The health care team and the surrogate decision-maker may have difficulty applying the written document's directive to the actual case at hand.

Module 4: Confidentiality and Truth

Section I: Confidentiality

The concept of confidentiality is an extremely important one in health care. When we honor the confidentiality of a patient, we agree to keep their health care secrets, so to speak. The trusting relationship between health care provider and patient is based in part on the patient's assumption that we will use their confidential health information only for the treatment of his/her illness and will not disclose that information unnecessarily.

As respiratory therapists, we have access to information about our patients that helps direct the care they receive. We discover this information in a variety of ways: directly from the patient, documentation in the written or electronic chart, and from other health care providers. It is important that we manage this information in a respectful manner. However, there are significant challenges to maintaining confidentiality. Increased access to electronic data, data transmissions via fax, and information in electronic mail are some of the challenges that may result in a violation of confidentiality. In addition, some health care providers conduct patient care discussions in public areas where non-health care providers can overhear these confidential details.

Section II: HIPAA

To help protect the patient's right to privacy, the U.S. Department of Health and Human Services issued the Health Insurance Portability and Accountability Act (HIPAA). A major goal of HIPAA "is to assure that the individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being" (p. 1).[8] HIPAA identifies many pieces of information as confidential: any identifiers such as name, address, gender, and date of birth; medical information such as diagnosis, condition, medications, and treatment details; social information such as family/social relationships, housing, and occupation; and psychological information such as emotional and psychological state. This information should be shared on a need-to-know basis with only those health care providers who are involved in the treatment of the patient. Let's evaluate a scenario where confidentiality might be in jeopardy.

Section III: Privacy

Meeting the patient's expectation of privacy is very important for all health care providers. It is tempting to access patient data of persons of interest to us: a celebrity, a family member or a neighbor. Respiratory therapists should always remember that patient information is on a need-to-know basis and should not be accessed unless the therapist is providing direct care to that patient. Violating patient confidentiality could result in disciplinary action taken by the hospital as well as the state respiratory care licensing board.

In general, patients must consent to have their information shared with a third party, like an insurance company or an out-of-network physician. However, there are some very good reasons for breaking confidences. Legal exceptions to confidentiality include emergent

situations in which keeping the confidence will harm the patient; situations in which the patient lacks decisional capacity and a surrogate decision-maker needs information to direct care for the patient; a third party is at serious risk of harm, as in child abuse, elder abuse, domestic violence, or transmission of sexually transmitted diseases; and when requesting the commitment of a psychiatrically ill person.[1] In some situations, the law doesn't just allow for violations of confidentiality; rather, the law mandates reporting of situations. These include the previously mentioned cases of child abuse, elder abuse, and domestic violence as well as infectious diseases such as tuberculosis; HIV infection; drivers impaired by diseases such as seizures, sleep apnea, and dementia; and any injury caused by weapons or crimes.[5] A good rule of thumb to follow is that the patient or the law must authorize release of information. Without one of these authorizations, the information should not be disseminated. It is also important to remember that the health professional has the burden of minimizing harm related to privacy and confidentiality.

Module 5: Professionalism and Scope of Practice

Section I: Professional ethics

The word "professionalism" is tossed around a lot in healthcare. We should "act like a professional" and "display professionalism." What does that really mean? From the Webster Dictionary, "professionalism" means that one is "engaged in one of the learned professions" and is "characterized by or conforming to the technical or ethical standards of a profession." Most respiratory therapists would agree that the profession requires a high level of training and proficiency; however, does that automatically make a respiratory therapist a professional? Society has very distinct expectations of health care professionals (HCP). Understanding those expectations and the role of professionalism in the respiratory therapist's career is vital for the profession to move forward.

The first societal expectation is that the HCP demonstrate minimum competency with professional credentials. Earning the Certified Respiratory Therapist (CRT) credential is the first step in a respiratory therapist's professional career. Taking that career to the next level with the Registered Respiratory Therapist (RRT) credential or one of the many specialty credentials offered by the National Board for Respiratory Care (NBRC) demonstrates that the therapist values advanced patient care. Falling in line with obtaining the credential is maintaining that credential. State licensing boards provide the respiratory therapist with a license to practice as a Respiratory Care Practitioner (RCP). Participating in the NBRC's Continuing Competency Program renews the credentials of the respiratory therapist while following state licensure requirements renews the professional license. Non-participation in either or both violates the societal expectation and may reduce the level of confidence placed with that respiratory therapist.

How the profession maintains knowledge and skills relates directly to maintaining these necessary elements. Society expects the HCP to maintain (if not improve) skills and knowledge while practicing as a professional. There are many ways to accomplish this: annual "blitz" days at hospitals and other healthcare agencies; conferences and meetings; attending training sessions on new pieces of equipment, and online continuing education courses. Continuing education benefits the therapist on a number of levels. The events that provide continuing education and skill development opportunities can also be applied toward both the NBRC Continuing Competency Program and state licensing board requirements.

Thirdly, society expects that each profession establish a code of ethics. Most health care professions have these codes of ethics; respiratory therapy is no exception. The American Association for Respiratory Care (AARC), the professional organization for the profession, has developed a statement addressing ethics and professional conduct. The AARC and other professional organizations recognize the need for guidelines in helping members of the healthcare professions to maintain high ethical standards. If one were to itemize the professional codes of ethics across the health disciplines, he/she would discover some common themes: respecting human dignity; safeguarding the patient's right to privacy and maintaining confidentiality; providing safe and competent care; maintaining professional competence and participating in activities to further develop one's education and body of

knowledge; safeguarding the patient and public from misinformation; and collaboration with other healthcare professionals to promote efforts to meet the needs of the community or patient. Following these standards increases the level of trust society places with both the individual and the profession as a whole.

Conforming to standard of care is another expectation. These standards are medical guidelines that direct appropriate treatment protocols based on scientific evidence. These standards provide a basis for clinical decision-making in the treatment of a given condition regardless of patient circumstance. Under-utilization of care, care that is necessary for the wellness of the patient that is not provided, is a gross violation of standard of care. On the other end of the spectrum, overutilization of care-unnecessary and excessive care-is also a violation of standard of care. Both of these violations affect the perceived professionalism of the profession and, in some cases, the individual therapist.

Section II: Scope of Practice

The responsibilities of the respiratory therapist are very diverse. The term "scope of practice" describes the range of responsibility for the respiratory therapist. According to the AARC position statement addressing scope of practice, the respiratory therapist's scope of practice includes the application of technology and the use of treatment protocols across all care sites including, but not limited to, the hospital, clinic, physician's office, rehabilitation facility, skilled nursing facility and the patient's home. The formal wording is usually found in the licensure law from the state in which the respiratory therapist is practicing. The difficulty in identifying the scope of practice is that it needs to be broad enough to encompass growth in the profession as new developments naturally occur in the maturation of the profession but it also needs to be narrow enough so that the limits to the respiratory therapist's duties are clearly defined. The goal is to ensure that persons who are not competent (in other words, neither educated nor credentialed) will not encroach upon the profession.

Section III: Practicing outside the scope of practice

It is very important to understand that the scope of practice for respiratory therapists may vary from state to state. The respiratory therapist should actively seek out his/her state's licensure, as there are serious negative consequences to practicing outside the stated scope of practice. The consequences of violating scope of practice can range from light penalties such as letters of reprimand to heavy penalties, including criminal charges, and various levels of consequence between the two extremes. These can include restriction of the licensee's scope, suspension of the license, and revocation of the license. The severity of the penalty is dependent upon the severity of the violation.

In addition to the state-enforced licensure rules, hospitals also have their own version of scope of practice. These are called job descriptions and they outline the scope of practice for the respiratory therapist within that specific organization. For example, though the state-defined scope of practice might include the ability to perform duties associated with extracorporeal membrane oxygenation, the hospital policy might not. If the respiratory therapist is found to be practicing outside the hospital's job description, he/she may suffer

legal consequences and may not be covered under the hospital's liability insurance. Let's review two cases in which scope of practice was violated.

Module 6: Continuing Education

Section I: Continuing Education and Clinical Competency

It is well known that health care research grows in breadth and depth of knowledge at a very fast rate. This growth in research provides us with new information about basic and applied biological and physical science, diagnostic methods, emerging pharmaceuticals, and various other medical technologies. The information gained during formal respiratory therapy education is sufficient to enter the workforce and obtain initial licensure. However, in the face of these rapidly developed technologies, the baseline education obtained during formal education is not enough to support the day-to-day activities of respiratory therapists as they progress through their careers. Some researchers have cautioned that the "respiratory therapists' usefulness to their patients' well-being is threatened by obsolescence due to the phenomenal growth rate of new knowledge and information" as it relates to the medical field and to the respiratory therapist's scope of practice.[9] Engaging in continuing education can provide respiratory therapists with the tools they need to effectively care for their patients.

Continuing education is the learning process used by professionals to keep abreast of changes in their respective fields to improve the quality of services they offer.[10] In the context of respiratory therapy, continuing education can help the therapist maintain his/her knowledge and skill while providing new information to modernize the therapeutic and diagnostic techniques learned in formal education.

One way continuing education for respiratory therapists is promoted is by the requirements of state licensure. As of January 2014, 49 states plus Puerto Rico and Washington DC have state respiratory care licensure acts. Of the states and territories with licensure acts, 43 states plus Puerto Rico and Washington DC specify minimum continuing education requirements. Various states also mandate continuing education in areas such as ethics, bioterrorism and disaster planning, and patient safety. Failure to provide proof of minimum continuing education credits can result in a variety of actions from the state respiratory care board, including loss of license.

In addition to state licensing requirements, the National Board for Respiratory Care (NBRC) has established minimum continuing education requirements for maintaining active NBRC credentials obtained after June 1, 2002. This program is called the Continued Competency Program. These requirements differ based on the credential combination earned by each respiratory therapist. If the respiratory therapist does not provide the proof of continuing education to the NBRC, his/her credentials will become inactive. This means that the therapist can no longer use the credentials behind his/her name until the NBRC receives appropriate documentation and verifies that the credentials are active. Most continuing respiratory care education activities that are accepted by state respiratory care boards will be accepted by the NBRC.[11] The respiratory therapist should read the Continued Competency Program information to determine what requirements apply specifically to his/her credentials.

Continuing education activities are not spontaneous learning events, though just-in-time learning activities such as inservices can benefit the health care professional. Continuing education learning activities are planned educational opportunities that focus on a specific aspect of the respiratory therapist's scope. Perhaps the activity focuses on a current concept in respiratory care or updates the therapist on new research that will result in an emerging concept. These activities are designed around behavioral objectives; in other words, what the respiratory therapist will be able to demonstrate after the activity is complete. The teaching strategies and evaluation methods are in line with the stated objectives of the activity and the faculty who lead the activity are qualified within the context of the topic. In some cases, the state respiratory care board will ask to see these objectives to determine the appropriateness of the learning activity.

Section II: Continuing Education and Patient Safety

Patient safety is a vital component of the continuing education of all health care providers. In the past 25 years, several landmark reports have been published to highlight the issue of patient safety in health care and how health care providers can improve patient safety. The National Institutes of Medicine (IOM) has been highlighting patient safety issues since 1999 with "To Err is Human," a document highlighting the failure of the medical malpractice framework.[12,13] Since then, the IOM publications have focused on faulty systems in health care and how those systems can be reconfigured to improve patient care. In the 2003 publication "Health Professions Education-A Bridge to Quality," the IOM identified five core competencies that are necessary for competent practitioners: patient centered care; interdisciplinary teamwork; evidence-based practices; quality improvement approaches; and using information technology. However, it is important to note that the IOM did not endorse continuing education as the sole method of demonstrating competence. Indeed, the IOM recommends continuing education in addition to regular competency assessments with remediation to document that the respiratory therapist can indeed demonstrate safe and effective patient care procedures.[14]

Respiratory therapists are ethically and, in most states, legally obligated to engage in continuing education for the benefit of their patients. Continuing education can improve confidence in patient care techniques and theory while also improving patient safety and keeping the community's trust in health care providers. Continuing education not only serves the needs of the respiratory therapist but also the needs of health care organizations and the needs of the public. Let's explore a case that exemplifies the need for continuing education.

Module 7: Conflict of Interest

Section I: Defining conflict of interest

In module 2, we discussed various ethical theories. Deontology, one of the theories we discussed, places focus on the duty or obligation we have to others. This theory's basic point is that the ends do not justify the means. Whenever a health care professional promotes his/her own best interests over that of the patient, it is said that a conflict of interest exists. A conflict of interest is defined as a situation in which a person entrusted with the interests of another (in our case, a patient) tends to be influenced in decision-making by a secondary interest.[15] A common conflict of interest noted in health care is that of a pharmaceutical company influencing a physician's preferred prescription. If the pharmaceutical company provides the physician with an all-inclusive vacation to a sunny resort, the physician is more likely to prescribe that company's medication. While this example showcases a physician and his prescription preference, the potential for conflict is noted at all levels of providers within health care institutions.[5]

Other conflicts of interest may include financial conflicts such as reimbursement incentives, personal investments in medical facilities, and gifts from industry. For example, a physician's decisions about a patient's care plan may be unduly influenced by his status as a part owner of the long-term acute care facility where the patient resides.

A unique conflict of interest occurs during the organ donation process. The decisions about the care of the donor must be made separately from the organ procurement decisions. The donor's physician cannot also function in the role of procurement physician as this would put the physician in the a role where he/she would have to choose whether to advance the best interests of the donor or those of the recipient.

Another unique situation is the fiduciary responsibility of persons elected to a governing body or board. For example, persons elected by their peers to serve on a state respiratory care society board have a fiduciary responsibility to the members of that society. When making decisions as a board member, they must put the interests of the society in a primary position over their employment interests. In some cases, it is nearly impossible for the person in question to manage the conflict of interest and they may have to recuse themselves from participating in the decision-making for that particular issue.

A common conflict of interest experienced by respiratory therapists is that which occurs when a product specialist employed by a company provides continuing education. The intent of the educational event is to increase the respiratory therapists' knowledge of the subject matter, which can encompass a wide variety of topics applicable to the respiratory therapists' scope of practice. The speaker chosen for the event must be able to disclose his/her conflicts of interest and manage that conflict in such a way that the educational content achieves the course objectives and does not result in a commercial for the sponsoring company.

Section II: Differentiating between real and perceived conflicts of interest
Sometimes, there is no "real" conflict of interest but rather one that is perceived by others. A real conflict of interest is one we just discussed: a financial or professional conflict that might exert influence in the decision-making process. A perceived conflict is one that presents minimal, if any, harm but the public perception of that conflict can be damaging.[5] A common example of a perceived conflict is the distribution of ink pens, note pads, or other small items with the company's brand imprinted on the item. If the person using the pen does not have prescribing or purchasing power, there is no influence on the decision-making process. However, it is the perception of others that the facility may be unduly influenced if their employees use that gifted item.

Section III: Managing situations in which a conflict of interest exists
It is important to understand that conflicts of interest are common and can be managed effectively to the benefit of all involved. When managing situations in which a conflict of interest exists, it is important to prioritize patient care. Treating the patient according to standard of care for that patient's unique medical situation is imperative and should not be unduly influenced by industry marketing. Disclosing the conflict of interest is of utmost importance prior to any contact.[5] When delivering an educational activity, persons with conflicts of interest must disclose these conflicts prior to delivering the content. In some situations, it is most important to restrict actions or situations in which the person may participate, similar to the example of the state respiratory care society board member recusing himself mentioned previously in this module.

To review the key points of this module, let's look at some cases that involve conflicts of interest.

Module 8: Illegal and Unethical Acts

Section I: Identify common unethical or illegal acts that result in disciplinary action
This module will discuss fraud as it applies to the respiratory therapist. Fraud is a term that is defined as an intentional act of deception that results in personal gain for the perpetrator.[15,16] This willful and intentional misrepresentation could cause harm to a person, a group of persons, or an organization.[17] Frequently paired with fraud is "abuse." In the context of this module, abuse is defined as an improper act that is unintentional but is not consistent with standard practices.[16]

There are many different types of fraud committed in the health care arena. These may include billing for services not rendered, false claims for services provided, duplicate billing practices, falsifying patient diagnoses, kickbacks, and misrepresenting procedures performed. Other forms of fraudulent acts include changing the billing practices of approved procedures. One example is to "upcode" the service provided to increase the reimbursement for that procedure. Another example is the "unbundling" of procedures. This practice involves billing for each stage of a procedure separately to collect more reimbursement.[15,16]

Section II: Identify the three basic elements of fraud
There are three basic elements of fraud. Initially, one must prove that the statement that is untrue is *known* to be untrue and the person who made the statement did so with the intent to deceive. It's important to remember that a simple mistake is not fraud; fraud is an intentional act.

Secondly, it must be proven that there is a justifiable reliance by the victim that the statement could have been true. In other words, the person who is deceived must believe the deception. This means that if you lie to me and I know your statement is a lie, I cannot claim fraud because I didn't believe your statement.

Lastly, it must be proven that damage resulted from the victim's reliance on the untrue statement. There must be a clear relationship between the false statement and any sort of damage. Let's look at a quick scenario that demonstrates fraud.

Section III: Identify the consequences of committing fraud
There are many state and federal laws that define, prohibit, and punish fraudulent acts. As a licensed respiratory therapist, you may lose your license to practice if you are found guilty of committing fraud. In addition to losing your license, there is a very real possibility that you will be liable for criminal and/or civil charges, too. Let's consider the previous situation involving David and Kim. Both of these respiratory therapists could be prosecuted if they commit the fraudulent act and the hospital chooses to report the crime. Penalties may include loss of job due to fraudulent activity, civil charges to recoup the fraudulently gained wages, criminal charges (depending on the amount of money), and loss of respiratory care license to practice in that state. It is also important to remember that Medicare, Medicaid, and insurance fraud is a significant problem and costs taxpayers

millions of dollars each year. Persons who are found guilty of insurance fraud are subject to prison sentences and/or significant fines.

Module 9: Ethics of Biomedical Research

Section I: Biomedical Research

Before we can understand the impact of biomedical research on the respiratory therapists' practice, we need to understand how biomedical research became a major component of health care. Research is the collection of data in a systematic and organized manner with the intent to disseminate, or publish, the results. During this process, there are many opportunities for the study process, the research subject, and the researcher to become compromised. The widely recognized principles of ethical research include integrity, respect for persons, and beneficence. As we explore the history of human research, we will identify the events that were the catalyst for these principles.

Section II: Directives for Biomedical Research

One of the most recognizable breeches in research ethics is the medical research conducted by German researchers during World War II. Many researchers conducted experiments on prisoners in the concentration camps. The majority of the experiments sought to test the limits of the human body and the effects of various medications. After World War II, an investigation into the research experiments showcased how many prisoners were significantly harmed, maimed, and killed. One of the results of the war crimes tribunal was the Nuremberg Code. This document detailed expectations of human experimentation, stating that proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability, or death.[18] Details of the code included that voluntary consent from the research subject be obtained, animal studies must be conducted prior to the human trials, the risk to the human subject must be relative to the humanitarian importance of the research, the researcher must be qualified, the human research subject may terminate the research without consequence at any time, and the researcher must terminate the experiment if cause for injury is found.

In 1964, the World Medical Association extended the Nuremberg Code at its meeting in Helsinki, Finland. The extension of this code, called the Helsinki Declaration, asserted that absolute priority be given to the subject over the interests of science and technology. This declaration has been revised several times but the intent remains.[19] Both the Nuremberg Code and the Helsinki Declaration focused on non-maleficence to the human research subject.

While the German research trials were one of the most widely publicized research ethics violations, it was certainly not the only breech of research ethics. In 1926, the U.S. Public Health Service began working with what was then called the Tuskegee Institute in Alabama to record the natural history of syphilis. The aim was to justify a treatment program for African-American males afflicted with the disease. These men were of a lower socioeconomic demographic in rural Alabama and were unable to afford health care. The human research subjects were compensated for participation with free medical examinations, free meals and complimentary burial insurance. The program was planned for six months when it began in 1932. The study actually lasted for 40 years and over 600 men participated.[20]

The ethical problems with the Tuskegee Institute study are numerous. The main issue was a violation of autonomy: no one told the participants how syphilis was contracted. Rather, they were told that they had "bad blood," a term used to describe numerous ailments at that time. The researchers didn't think that the participants had the intelligence to understand the meaning of "syphilis." Therefore, the participants were not fully informed prior to consent. Another ethical issue is a violation of beneficence. In 1928, penicillin was discovered but it wasn't widely used until the 1940's. Those persons who participated in the study during the time when penicillin was available were not offered treatment at all. The result of these ethics violations was a significant loss of trust in government-initiated health initiatives and a development of skepticism towards participation, especially in those vulnerable populations. Communities are further damaged by the loss of benefit that might result from research.[21]

After the Tuskegee Institute study ethics violations were discovered and reviewed, the U.S. Department of Health and Human Services issued the Belmont Report. This report was released in April 1979, and summarized basic ethical principles for human research: respect for persons, which includes the individual's right to make decisions and informed consent; beneficence; and justice.[21]

The directives asserted in the Belmont Report are still pertinent in modern research. Informed consent, as the kind obtained for medical procedures, must include certain components. The human research subject must voluntarily consent to research and must not be coerced. There are many sources of coercion: financial gain, pressure from family or friends, pressure from the health care team, or fear of losing the patient-doctor relationship. The consent obtained must be given once the subject is completely informed. Consent is not simply a signed piece of paper; rather it is the process of agreement and that process is ongoing. Continual reassessment of the subject's comfort level with the research is necessary. Lastly, the person giving consent must have decisional capacity.[22] As with all consent processes, the subject must be able to understand the risks and benefits of study participation and be able to make decisions based on his/her values. In some cases, a surrogate decision-maker may be necessary to obtain appropriate consent. Let's examine a case where informed consent for research may be in jeopardy.

Section III: The Role of the IRB

There are many other examples of ethics violations in research, both in the United States and abroad. These violations over the span of many years prompted the U.S. Department of Health and Human Services to develop a Code of Federal Regulations (CFR) that protected the public from exploitation in human research. This code, 45CFR46 (Title 45: Public Welfare; Part 46: Protection of Human Subjects), asserts that most research must comply with a federal agency for approval and monitoring of all actions. The monitoring body for research is called the Institutional Review Board (IRB). The IRB evaluates safety to persons and the risk-to-benefit ratio. The IRB reviews research in studies funded or supervised by the federal government. The regulations for human research under 45CFR46 are very specific and heavily regulated.[22]