Patient Rights

Background of Patient Rights

One of the imperative variables that need to be considered and dealt with in the healthcare framework is the right of the patients. Patient rights are strict cases made by persons looking for and utilizing health resources. Since an actual right commits somebody or some substance to secure or give something, healthcare professionals and organizations are in charge of recognizing, regarding, securing, and supporting patient rights. At the center of the therapeutic choice making procedure are noteworthy patient rights for instance, the rights to be dealt with deferentially, to take an interest in choices influencing one's wellbeing and future, and to have one's close to home restorative data kept classified. Amid the previous 50 years, particularly in North America and Western Europe, there has been huge improvement in recognizing what ought to be incorporated among patient rights (Diefenbach, 2008).

History of Bill of Rights

The Bills Of Rights were added to the U.S. Constitution in December 15, 1791. They consist of the basic 10 amendments; other amendments were added down the years. Not all of them involve rights, but many do. The first ten amendments, in particular, have the special name of the Bill of Rights. They are meant to protect the rights of all Americans. They protect our liberties and freedoms from the government. Without the Bill of Rights, the government can do whatever they want to us (Grace, & McLaughlin, 2005). The Bill of Rights was passed because some people were afraid that the government, or the police, would be able to keep people from doing some very important things. The belief that all men are created equal is implemented to all American citizens. Today, the idea of a United States without a Bill of Rights is scary. For example, you can say whatever you want about the President, but the only reason that is possible is because of the Right of Free Speech that the Bill of Rights guarantees.

Based on the U.S. Declaration of Independence's rights of “life, liberty and the pursuit of happiness,” the Civil Rights Movement and its core values emphasized dignity and respect owed to all persons and equal opportunities and freedom for each person to live, work, be educated, and participate in society. In the 1960s and 1970s, a second set of events leading to the patient rights movement were revelations that many persons had been abused as research subjects.

Through the Nazi war crimes trials at Nuremberg (1945–1949), the world learned about the atrocities that occurred in Germany in the name of science before and during World War II. However, two decades after the war, as the medical research enterprise continued to expand, there was publication of instances of exploitation of vulnerable persons (e.g., those with mental disabilities, children, orphans, prisoners, African Americans) in the name of scientific advancement (Grieves, Stein, & Stevenson, 2004).

Specific Patient Rights

Dignity, Respect, and Nondiscrimination

The right to be treated with dignity and respect is founded on the recognition that patients are vulnerable, have diminished power and authority in healthcare settings, and need to be protected from exploitation and discrimination. Treating patients with dignity and respect includes honoring personal privacy, appreciating and trying to meet spiritual or religious needs, accommodating cultural beliefs and practices, and ameliorating pain. The right not to be discriminated against derives from the ethical principle of distributive justice or fairness, requiring that patients with similar needs be treated similarly. Race, ethnicity, religious beliefs, sexual orientation, and socioeconomic background are rarely, if ever, relevant for the provision of quality treatment and care. However, these patient characteristics are relevant to patients' experiences of care as respectful and dignified. A patient's gender and age can frequently be relevant for determining some diagnoses and treatment plans; nevertheless, these patient characteristics should never be the basis for sub quality care or under treatment.

Open Lines of Communication

Communication

Patients' right to information facilitates and supports other rights. For example, patients who do not receive relevant, adequate, and current information about their care are not given due respect and subsequently are unable to participate in informed decision making. Information to which patients have a right includes knowing who their healthcare providers are; the nature, purpose, risks, benefits, and alternatives of proposed treatments or diagnostic procedures; and whether the proposed interventions are research or standard of care. Language barriers can significantly hamper patients' abilities to exercise this right; consequently, some listings of patient rights include the right to language interpreters. The right to information also includes disclosure of medical mistakes, especially if mistakes result in significant patient harms. The right to information is not limited to medical information but includes information about the financial aspects of care and how anticipated outcomes of interventions will affect a patient's quality of life.

Decision Making

The right to make one's own healthcare decisions is fundamental to and well established in U.S. healthcare delivery. The ethical principle of patient autonomy or self-determination supports this right. Implied by this right is the belief that a patient has adequate cognitive skills (i.e., competence or decision-making capacity) to participate in the decision-making process. This right also implies not only that patients can and should authorize treatments but also that they can refuse treatments. This right does not allow patients to demand treatments or procedures that are medically unnecessary. Therefore, the expertise of physicians and other healthcare professionals is essential for educating patients about the proposed procedures and making medical recommendations. However, the right recognizes that patients also have expertise relevant to the decision-making process; that is, they are experts as to their own values, preferences, wishes, and life goals. In pediatric care, this right to participate in decision making is extended to children able to understand age-appropriate healthcare information (usually at about age 6 or 7); although these children lack the cognitive skills to consent to treatment, many can provide assent or agreement to treatment.

Privacy and Confidentiality

The right to personal privacy and to have health information held in confidence is supported by the ethical principle of respect for patient autonomy. Privacy not only implies noninterference in personal healthcare decisions but also extends to aspects of the healthcare environment, such as having one's body appropriately shielded from others' view whenever possible and having discussions about medical conditions conducted in private areas (not, e.g., in public areas such as elevators, corridors, and cafeterias) and only with those professionals who need to know. Some elements of this right were codified in U.S. federal law in the Health Insurance Portability and Accountability Act (HIPAA). Under HIPAA, patients must authorize disclosure of their protected health information; and they have the right to obtain copies of their medical records and submit amendments if the medical records contain information with which patients disagree. HIPAA also requires healthcare institutions to maintain strict confidentiality through multiple procedural safeguards. The American Hospital Association's (AHA's) Patient's Bill of Rights, published in 1972, included similar language regarding patient privacy and confidentiality (Latifi, Ritat, 2008).

Quality Healthcare

The provision of healthcare is intended to benefit patients by promoting and maintaining health, curing diseases and disorders, and ameliorating pain and suffering. In essence, patients should be able to expect that healthcare professionals, with appropriate expertise in accord with their roles in the healthcare delivery process, will promote patients' best interests and well-being. The ethical principles of beneficence and nonmaleficence support this right and the expectation that healthcare professionals will consistently try to maximize the benefits of medical interventions and minimize harms and risks. To help promote and honor this right, healthcare organizations and professionals have the responsibility of engaging in continuous quality improvement processes so that systems are improved, efficiencies are maximized, patient safety is enhanced, and errors and near misses are reduced.

Access to Emergency Care

In the United States, there is no recognized general right to healthcare, although a few states (e.g., Oregon, Hawaii, and Massachusetts) have made efforts to provide access to basic healthcare interventions for all their citizens. However, under the Emergency Medical Treatment and Active Labor Act (EMTALA), persons in the United States have a right of access to at least emergency treatment and care. EMTALA is a federal law requiring hospitals with an emergency department to assess and stabilize all patients who present to their facilities regardless of the patient's ability to pay for services. Patients can be transferred to other facilities if the facilities where the patients initially presented do not have appropriate medical or surgical expertise to meet their needs. Many patient bills of rights include a right of access to emergency care in accord with this federal mandate. Many patients in the United States, primarily because of their indigence or lack of health insurance, have access to healthcare resources only through emergency departments and therefore present themselves to emergency departments even for nonemergency medical conditions.

References

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