KEY TERMS

culture shock
disparagement
gaming the system
gatekeeping
joint-venturing
moral duty
moral option
patient advocate
role fidelity
scope of practice
self-referral
Stark Law

Our responsibility is not discharged by the announcement of virtuous ends.

John F. Kennedy

There are two educations. One should teach us how to make a living and the other how to live.

John Truslow Adams

CODES OF ETHICS AND PROFESSIONAL CONDUCT

Historically, the essential characteristics of the learned professions (education, clergy, law, health care) are self-regulation, a specialized body of knowledge, standards of education and practice, a fiduciary relationship with those served, and the provision of a particular service to society. Most often the professional groups operate under a legal practice act and develop a code of professional conduct and ethics to assist in self-regulation. These documents have as a purpose the binding of a group of practitioners together.

- They express the aims and aspirations of the group
- They promote integrity, dedication and principled behavior
- They provide guidance as to appropriate conduct

Codes of conduct and ethics are common within the many specialties of health care. Regardless of specialty all must deal with similar ethical and moral problems. These include:

- Appropriate scope of practice
- Conflicts of interests
- Serving the best interest of patients
- Obligations to promote patient autonomy and privacy

- Obligations beyond patients to others in the society
- Ethics of research
- Informing on unethical or illegal behavior of colleagues

Our specialty codes set out the principles of ethical and moral conduct as they relate to our particular specialty. The language within these codes is usually general in nature as to levels of expected performance, and therefore the fair enforcement of the rules is difficult. Common problems associated with professional codes are:

- Vagueness as to duties and prohibitions
- Incompleteness as to duties
- Excessive concern with promotion and prestige of profession
- Vagueness in regard to self-regulation and peer enforcement
- Excessive concern with financial and business interests

Codes of ethics and conduct often require interpretation by practitioners as to their application to a particular problem. Our codes of ethics and conduct even coupled with institutional rules and common sense are often insufficient to handle the dilemmas that arise in modern health care. When we review our profession's code, we often fail to find a solution to the problem among the listed rules and must turn to reason for answers. Therefore, there is a definite need for ethical theory and guidance as we seek to solve the specific moral dilemmas and problems we face.[1]

CASE STUDY

A study regarding Navajo culture indicates that there are problems associated with the legal requirements of the Patient Self-Determination Act that requires the practitioner to discuss life-threatening conditions and seek to elicit answers regarding the patient's wishes in regard to the use of life-supporting technologies. The problem lies in the fact that within the traditional Navajo culture in times of illness, there is a need to speak and think positively and avoid the negative. The requirement that health care providers review all material adverse possibilities seems to go against the need to remain positive in the face of illness.

1. Given that the requirements are designed to promote patient autonomy and are legally required, what is the practitioner to do?

DISPARAGEMENT OF PROFESSIONAL COLLEAGUES

As a member of a health profession, you have an obligation to be a peer to others on the health care team. Part of these obligations can be considered gatekeeping functions whereby you look out for the interests of the profession and of others in a similar practice. This sense of collegiality and mutual support is found in the earliest of codes when new practitioners undertook obligations to their teachers and the professional guild. The following statement is found in the Standard English translation of the Hippocratic Oath.

> I swear by Apollo Physician and Asclepius and Hygieia and Panaceia and all the gods and goddesses, making them my witnesses, that I will fulfill according to my ability and judgment this oath and covenant:
>
> To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art if they desire to learn it without fee and covenant; to give a share of precepts and oral instruction to all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but to no one else.

The new practitioner, in taking the oath, bound himself to share knowledge only with those within the guild and to treat other practitioners equal to members of one's own family. From these early practices have come a series of traditions within the professions: to avoid the **disparagement** of other practitioners, share new therapies and technologies, offer professional courtesy for services, avoid sexual and other conflicts of interest, and look after the general welfare of the profession and those in practice. An unfortunate case of disparagement of colleagues occurred in the early 1980s when an allied health educator became disturbed by the number of ill-advised resuscitation efforts being called for in the local hospitals. To bring attention to the practice and to bring about needed reforms, the therapist wrote the following article for his local society newsletter:

> A month or so ago, a young lady who had had two heart surgeries and a couple of (cardiac) arrests during the past two years, which resulted in hypoxic brain damage that had left her feeble minded and with a convulsive disorder, arrested again at home one evening because of a failed pacemaker. She was resuscitated and brought into the hospital, with no oxygen in the ambulance. There in the medical intensive care unit where everyone knew her from prior admissions, she arrested AGAIN about an hour later. Since she was not red-tagged, we were obliged to resuscitate her AGAIN, and put her on a ventilator. There she literally rotted away for three or four weeks (they had promptly fixed her pacemaker so that her heart wouldn't be able to stop again), until in spite of hell (which included dialysis for renal failure for over a week) she finally managed to "die."
>
> Now, if one of the male staff had jumped into her bed and raped her, this would have been regarded as a criminal assault, and everyone would have been outraged, right? But what we did was far more damaging physically, far more protracted, and not one whit less immoral. Just the same, in the eyes of our curious social system, it was OK. Some system![2]

Thankfully, our systems and procedures regarding DNR orders have changed since the early 1980s when the therapist wrote the article. But even if you think the therapist was right in his outrage, the disparaging (talking ill of) fellow health care providers became the issue. The point of the matter was not whether he had an obligation to bring this problem to the attention of others and seek resolution; the problem lay in his presentation. Often in questions of morals, we feel so intensely about what we consider to be wrong that we consider those who do not share our point of view not merely wrong, but evil. His article went well beyond presenting a legitimate problem when he likened the physicians' practice to criminal assault and rape, or reckless irresponsibility. It is difficult to imagine that his manner of presentation gained him willing listeners among those he accused. Unfortunately, the article did not bring about the changes he sought, but instead harmed his career.

There are many problems in modern health care practice that need to be addressed, and the allied health practitioner and nurse have an important part to play in these discussions. The effectiveness of our input—the willingness of others to listen and to cause positive change—will have a great deal to do with the collegiality of our presentation and the positive nature of our proposals.

In practice, allied health and nursing personnel have long known that our physician colleagues were very loathe to criticize other physicians and practiced **gatekeeping** as part of their professional duties. This gatekeeping function, whereby one looks out for the interests of the profession or of others in a similar practice, comes as a result of our professional obligations and training, which lead to a strong sense of collegiality with others in our practice.

Yet as health care providers, we are often faced with the question raised by Cain: "Am I my brother's keeper?" As a member of a health profession the answer is often yes! Not only are we responsible for our actions in regard to the patient but we are also charged with the duty to ensure that the rest of the health team is practicing appropriate care.

IN THE NEWS

Quackademic Medicine

A well-respected physician who serves as full professor and Vice Chair of the Department of Surgery at an important American university medical center took on an additional position as host of a day-time television program. The program took his name, and became wildly popular with its focus on the physician giving advice on complementary medicine techniques and herbal supplements, such as those for weight loss. The show became so popular that his mere mentioning of a particular supplement often resulted in mega-success for the manufacturer.

The University received a letter signed by 10 physicians urging the University Medical Center to sever its ties with the physician, claiming that he is making a fortune promoting quack nostrums to the television audience. There appears to be a nugget of truth in the criticism, as the *British Medical Journal* reported that of 80 recommendations made from a sample of 40 episodes, showed that scientific evidence supported 40 percent, contradicted 15 percent, and was not found for 39 percent. Two of the descriptive characteristics of a profession are that they maintain a high standard of practice and are self-regulating. It is the self-regulating aspect that would allow fellow practitioners to report any colleague who did not maintain a reasonable standard of practice or involved themselves in unethical practice.

The physician states that he personally has investigated the various herbs he promotes and uses them in his own family. He feels confident in his recommendations, even if they are not backed up by scientific evidence.[3]

1. Is it right for the 10 physicians to have sent the letter to the university administration calling for them to sever his relationship with the medical center?
2. Would a letter to the physician's professional organization's ethics committee asking for an investigation of the physician's activities been more appropriate?
3. Would it matter if at least one of the letter signers promoted GMOs? What if another denied "Global Warming"? What if one had spent time in jail for medical fraud?
4. The physician said he would fight this call for his dismissal on the basis of his "right of free speech." While it is true that a physician promoting "nonscientific therapies" would be covered by his legal right to free speech under the First Amendment to the Constitution, would this be a protection against a professional claim of unethical practice?
5. Who is in the right in this matter: the celebrity physician or letter-writing colleagues?
6. Do you see this as a matter of law, ethics, or professional etiquette?

GAMING THE SYSTEM

Gaming the system was a term widely used with the advent of prospective payment systems and managed care. The term as commonly used means that the diagnosis or clinical condition is described in such a manner that the process stretches the truth or is fraudulent to get the plan to pay for a test that is not strictly covered or to pay at a higher rate. In the early days of prospective payment, some companies created software to assist in the process of gaming the system. Today, in the managed care arena, gaming is most often done to get around the time-consuming process of challenging the rules and applying for an exception to the rules for a particular patient.[4]

For our purposes, however, we will use *gaming* in a more general sense in which the practitioner is attempting to get around the system and is willing to lie in the process. Often the gaming is not even done for the practitioner's benefit but is being done in behalf of a patient or at a patient's request. The therapist who creates a paper trail that provides the basis for a longer period of rehabilitation therapy than would be allowed given the actual situation of the patient, or the physician assistant who certifies that an elderly patient with bunions needs a handicapped parking sticker, when in fact the severity of the problem does not meet the standard for authorizing the sticker, are both gaming the system.

It would seem that it would surely be more acceptable to game the system on behalf of the patient rather than for one's own benefit. Given the world in which we practice, where institutional rules and health care policy plans are not always fair, where our duties to third-party obligations are surely less binding than our obligation to the patients we serve, perhaps some think that we may have a duty to game. Do the health care provider's obligations to the patient's health or to the patient-provider relationship outweigh our duty to the principle of veracity?

CASE STUDY

A favorite childhood story is "Robin Hood." As the tale is told, Robin and his band of merry men steal from the rich and give to the poor. Although we are taught that stealing is wrong, in this case, we consider it good, perhaps even an example of distributive justice, as the rich get poorer and the poor get richer. Instead of being considered a thief, Robin is the hero of the story.

Can we equate the story of Robin Hood to a health care professional, who, to help a patient, bends or breaks the rules regarding access to care? Examples of this practice might be billing for an insured service while providing an uninsured service, or misrepresenting patient data, thereby exaggerating the severity of an individual patient's condition to obtain a longer period of care, which the provider feels is needed by the patient. If the health care provider, like Robin Hood, is doing these things totally for the benefit of others rather than self-interest, is he or she a hero?[5]

1. Given this is a health care ethics text, the answer of course is NO! Explain why.

As tempting as the thought is, health care practitioners have a fundamental responsibility to be truthful, to keep promises, and to be fair. Yet, gaming the system on behalf of patients in most cases produces no obvious injury and appears harmless, and given the great number of rules that seem arbitrary, it is easy to justify the practice in your mind and have it become a standard way of doing business. In her article "Gaming the Rules, Dodging the System," Morreim outlines several basic harms based on utilitarianism that are a result of these deceptive practices.[6]

- Lying inevitably undermines a person's credibility. Even when you are doing gaming at the request of the patient, as in the example of the handicapped parking sticker, you may in fact erode the trust between you and the patient. A patient who observes you lying *for* him cannot help but wonder whether you would be willing to lie *to* him.
- If an individual clinician is found to be lying, this can have a harmful effect on the entire health care profession. Much of the good we do is based on the trust we receive from the public and patients. If the public were to perceive us as unworthy of the trust, our ability to serve them would be lessened.
- Gaming can harm other patients. In a world of finite resources, if you somehow manage to get more resources for your patient, you may in fact be taking needed resources away from an equally or more needy patient. In the example of the parking sticker, when the handicapped slots are filled, someone has to walk farther. This may seem trivial but would not seem so for a patient needing an intensive care bed, only to find all beds full because another physician gained the bed for her patient by describing a stable angina as an unstable one. This practice would surely seem to offend distributive justice.

The principle of veracity has a long tradition in health care ethics that goes beyond the utilitarian seeking of a balance between good and harm. Philosophers such as Immanuel Kant held that truth is a fundamental duty for all individuals at all times and that those who lie offend human dignity. Whether you are comfortable with an absolutist view such as that of Kant or with assessing and weighing outcomes, the end result is the same. Within health care, there is a general assumption that deception is problematic even if it is motivated by good intentions.

CONFLICTS OF INTEREST

Under no circumstances may physicians place their own financial interests above the welfare of their patients. The primary objective of the medical professions is to render service to humanity; reward or financial gain is a subordinate consideration. For a physician to unnecessarily hospitalize a patient, prescribe a drug, or conduct diagnostic tests for the physician's financial benefit would be unethical. If a conflict develops between the physician's financial interest and the physician's responsibility to the patient, the conflict must be resolved to the patient's benefit.[7]

Council on Ethical and Judicial Affairs 1996

Patients have a certain vulnerability and dependence not usually found in other professional occupations. It is the essence of the therapeutic relationship and the trust that it inspires that makes individuals feel so betrayed and outraged when abuses occur.

LEGAL CASE STUDY

A medical center in Florida agreed to pay $85 million to resolve allegations they violated the False Claims Act and the **Stark Law**. The government alleged that the medical center contracted with six medical oncologists and provided them with incentive bonuses that improperly included the value of prescription drugs and tests the physicians ordered that the medical center billed to Medicare. It was also alleged that the medical center paid three neurosurgeons more than fair market for their work, and that the hospital admitted patients who did not need to be admitted and billed Medicare for their care.[8]

This case highlights enforcement of Section 1877 of the Social Security Act (42 U.S.C. 1395nn), also known as the physician self-referral law.[9] Physician self-referral is the practice of a physician referring a patient to a medical facility in which he or she has a financial interest, be it ownership, investment, or a structured compensation agreement. The *Stark Law* prohibits physician referrals of designated health services (DHS) for Medicare and Medicaid patients when there is an inappropriate financial interest. DHS services include:

- Clinical laboratory services.
- Physical therapy services.
- Occupational therapy services.
- Outpatient speech-language pathology services.
- Radiology and certain other imaging services.
- Radiation therapy services and supplies.
- Durable medical equipment and supplies.
- Parenteral and enteral nutrients, equipment, and supplies.
- Prosthetics, orthotics, and prosthetic devices and supplies.
- Home health services.
- Outpatient prescription drugs.
- Inpatient and outpatient hospital services.

Recently, in the literature, health care provider **joint-venturing** (where a group of individuals join together performing a business venture), and **self-referral** practices have been questioned. Most of these criticisms have been directed toward physicians who have

joint-ventured into health care services such as physical therapy, diagnostic imaging centers, ambulatory surgical centers, and durable medical equipment companies.

LEGAL CASE STUDY

The Greber case involved an osteopathic physician, board certified in cardiology. The physician formed a company that provided diagnostic services such as holter monitoring. The company would bill Medicare for the services provided and when payment was received forward a portion of the fee to the referring physicians. The rebate was described as an interpretation fee but was greater than that permitted by Medicare. In practice, the physicians receiving the rebates generally allowed the company to perform the interpretation.

In the Greber case the court ruled that the payments made to the physicians were to induce referrals rather than to perform professional services; that even in those cases when some interpretation was done by the physicians, the sum provided was greater than the services provided, and that a secondary intent was to induce future referrals.[10]

1. Who is the victim in this case?
2. Do you feel any of the physicians involved dishonored their fiduciary relationship with their patients? If so how?

As a matter of fiduciary good faith and pragmatic practice, any commercial relationship between a practitioner and a company, in which the practitioner has a material interest that could form the basis for a conflict of interest, should be spelled out in a disclosure statement. Examine the case study of the hard-working therapist in the light of conflicts of interest.

CASE STUDY

The Hard-Working Therapist

Sheryl is a respiratory therapy technician in a small town in Michigan. The town has a small hospital and a small durable medical supply company. Sheryl is known locally as an entrepreneur ball of fire and has managed to become both the head of the hospital respiratory care department and the owner of the small durable medical supply company.

1. In that most of the referrals for home care equipment from the hospital department where Sheryl works goes to her home care business, does this represent a conflict of interest?
2. What should Sheryl do?

Obviously, in some or even a majority of these instances, the patients are well served. In some cases, these joint ventures create a competitive atmosphere and may even provide services to a community that might otherwise be unavailable. In these instances, the joint ventures serve a patient-centered health care ethic, and perhaps rules need to be put into place to allow these clinics to continue to function.[11]

It seems clear that to self-refer to an establishment in which you do not provide service but have an economic interest is at least suspect and perhaps unethical. Yet there are other equally serious situations of conflict of interest that are more subtle.

What of the pens, writing pads, free texts, medical equipment, and drug samples that at times seem a normal part of the delivery of health care? Does the fact that the gift is small make it more ethical to receive? Millions of dollars are spent each year by drug companies to influence physicians in regard to their purchases. Where does this process of receiving goods from drug firms or equipment companies cease to be good advertisement and begin to be unethical? If you were invited to a free seminar held on a cruise ship—where your travel, housing, food, and entertainment were picked up by a company—would this be unethical or continuing education? Do these practices affect patient care in regard to what companies the patients were referred to or what pharmaceuticals were used? If the practices did change the behavior on the part of the health care practitioner, was the change brought about on the basis of new information gained or favors granted? The very fact that such questions can be asked should cause professional concern.

IN THE NEWS

Suspicious Connection

A Harvard Medical School study on the influence of pharmaceutical and medical-device companies on physician practice has resulted in the Medical School's creation of rules aimed at breaking the cash connection between physicians and companies. Many physicians resented the insinuation that their medical judgment was being affected by their relationships to these companies. From August 2013 to December 2014, drug and medical devices companies paid at least $3.53 billion to 681,432 U.S. physicians. The companies relate to physicians in a variety of ways from the seemingly trivial (e.g., dispensing of gifts such as mugs, pens, and pads with company names inscribed and picking up the tab for meals) to the more troubling (ghostwriting of articles for academic physicians, the payment of large honoraria and consulting fees, lavish trips, and entertainment for those who extol the virtues of company products). According to the study, the fees for consulting, speeches, travel, and meals, successfully "effect prescription practices and physician behavior."[12]

Although much has been written in regard to the joint venturing practices of physicians and their relationships with drug companies, it is very difficult to determine exactly where the line should be drawn. Reflections on these same practices can be found in the dealings of nursing and allied health professionals. How many of the national, state, and local meetings that these practitioners attend are underwritten by commercial companies? What is the purpose of the hospitality suites that offer an open bar and free food provided by companies during conventions?

Conflict of interest is not limited to the practice of physicians and is equally suspect as a practice whoever the health care provider is. A practitioner who changes his way of practice through any motive other than patient benefit has embarked on a slippery slope of compromised ethics. As a patient care provider, each professional needs to evaluate and prioritize to determine the point at which a service or provided gift ceases to be merely good advertisement or continuing education, and begins to be a favor offered to compromise the client-centered nature of our health care practice.

SEXUAL MISCONDUCT IN HEALTH CARE PRACTICE

Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slave.

Hippocratic Oath

It is generally held among all health care providers that sexual relations between practitioners and patients are unethical. This is true because the relationship between practitioner and patient is always unequal. The nature of the practitioner-patient relationship places the practitioner in a position of advantage in the critical areas of knowledge, power, status, and personal vulnerability. Often, very intimate relationships are formed on the basis of our roles, and these can be powerful and intense for both patient and practitioner alike. Moreover, these normal, caring relationships developed between provider and patient frequently evoke strong and complicated feelings. These emotions of admiration, caring, and trust can be misunderstood, and patients are especially vulnerable when they are experiencing intense pressures or major traumatic life events.

Because of these inequalities of position, sexual relations under these situations cannot be considered, nor can they be understood as representing the true consent on the part of the patient. Inasmuch as practitioners have an obligation to treat the needs of the patient first, their own personal gratification cannot become a consideration. The therapeutic relationship rests on the patient's belief that the health care provider is dedicated to her welfare and that there are no

other motives or considerations. Sexual relations, by their very nature, create emotional factors that interfere with the therapeutic relationship and the needed objective judgment. Whether because of a temporary failure to manage the therapeutic relationship or to crass exploitation of a professional situation, these relationships are neither ethically excusable nor condonable.

When the practitioner feels that a potential for misunderstanding is possible or that there is the potential for mutual feelings of romantic interest, it is time to end the professional relationship. In that the patient's feelings formed during a time of illness often extend beyond the health care situation, the termination of care does not in itself provide an ethical basis for such a relationship to blossom into sexual contact. If the practitioner is exploiting the feelings of regard, respect, trust, and vulnerability gained as a result of the patient-provider relationship, the ethical propriety of such action is still suspect. In regard to the obvious question of how long is an acceptable period of interruption of the association, the answer is whatever time it takes until the emotions derived from the relationship cannot be misused or manipulated.

CASE STUDY

Jason is a 24-year-old respiratory therapy practitioner who works the evening shift. One of his patients is a woman near his age named Gabriela who is in the hospital for acute asthma. Jason knows her age because he and Gabriela went to the same high school together, although she was in the class below his. He has not seen her since high school.

During the week she was hospitalized, he and Gabriela talked about the old high school days and he feel that have a lot in common. Jason feels that Gabriela is feeling some affection for him, but he keeps their relationship friendly but professional. On her last night in the hospital prior to her checking out, he hugs her and kisses her on the cheek, and she asks him to give her a call.

1. Now that Gabriela has gone home, is it okay for Jason to take her out?
2. What criteria should he use in making his decision?

SCOPE OF PRACTICE

The principle of **role fidelity** requires that we remain within our scope of legitimate practice. In most cases, the **scope of practice** is clear, and one does not cross the line without willful intention. For example, the nursing or allied health practitioner who is performing physicals and pretending to be a physician has not made an honest error. However, traditions and practices change, and sometimes the line is not as clear as one might suppose.[11] The following case outlines the problems that can occur as a result of being unclear as to specific duties, especially during a period in which there is a shift of traditional roles.

In the mid-1970s, a nursing educator in Idaho had contact, through a student, with a female client who had chronic myelogenous leukemia. This form of leukemia can often be managed for years with little or no chemotherapy. The woman had done well for twelve years and had ascribed her good health to health foods and a strict nutritional regime. However, her condition had turned for the worse several weeks before, and her physician had advised her that she needed chemotherapy if she was to have any chance of survival. The physician had also advised her of the potential side effects associated with the therapy, including the loss of hair, nausea, fever, and immune system suppression with the increased potential for infection.

The woman had consented to the therapy and signed the appropriate forms, but later had begun to have second thoughts. The nursing educator and student had given the patient one dose of therapy when she began to cry and to express her reservations in regard to the treatments. She questioned the nurse about alternative treatments to the use of chemotherapy. The patient related that she had agreed to the therapy because her son believed that this was the best treatment, but she also related that she had not questioned the physician about alternatives, as he had already told her that chemotherapy was the only treatment indicated. The nurse did not discuss the patient's concerns with the physician, and later that evening returned to the hospital to talk to the patient about alternative therapies. In the discussion, rather nontraditional and controversial therapies were covered, including reflexology and the use of laetrile. The woman's son and daughter-in-law were present at the time of these discussions. During the talk, the nurse made it very clear that the treatments under discussion were not sanctioned by the medical community.

The patient's feelings toward alternative therapies were strengthened by the evening's conversation, but she nevertheless decided to go ahead with the chemotherapy. The treatments, however, did not bring remission to her crisis, and she died two weeks later. The son who had been present during the discussion regarding alternative therapies related the conversation between his mother and the nurse to the doctor.

The physician brought charges against the educator for unprofessional conduct and interfering with the patient-physician relationship. The Board of Nurse Examiners for the state of Idaho charged her with unethical conduct and removed her license to practice. An appeals court later overturned the decision on the basis that the nursing standards used by the board to judge her conduct were too vague, and therefore it was an injustice to remove her license. Although she was somewhat vindicated by the court of appeals decision, the three years of struggle had cost the nurse her teaching position and harmed her career.[14]

Who was right in this case: the nurse, who acted upon the changing role of nursing to function as a patient advocate, or the physician, who, following his professional code, could not truly advocate alternative therapy? Had the physician done so, he would be violating the rule that physicians only practice medicine having a scientific basis.

What is meant by the term **patient advocate** in a situation such as this? Does it extend to excluding the physician from conversations that potentially affect the patient's medical decisions? The role of the nurse is changing, but even as late as 1985 two other nurse-patient relationship models beyond patient advocate were still being discussed. Under both of these, the bureaucratic model (in which the emphasis is on the maintenance of social order at the expense of the individual patient's welfare) and the physician advocate model (in which the goal is to enhance the authority of the physician), the nurse's actions could have been considered contrary to good order.[15]

But what if the appropriate model was that of patient advocate, and the nurse knew that the physician would not have been willing to talk to the patient about her concerns even if she had asked him? Would that have made the situation different?

- Would the nurse have a legitimate right to provide the information under the requirements of informed consent?
- Could informed consent require the discussion of treatments without a scientific basis?
- Does the fact that the nurse did not discuss the situation with the physician and came back during off-duty hours to discuss the matter with the patient indicate that perhaps she knew that the scope of practice line was being breached?
- Do you agree or disagree with the Board of Nurse Examiners decision to charge her with unethical conduct and removed her license to practice?

IMPAIRED COLLEAGUES

The practice of health care is often very stressful, and it is not surprising that certain providers have found themselves susceptible to alcohol and drugs. It is estimated that 10-15 percent of the nurses in the United States today are addicted to alcohol or other drugs, and in one state study more than 90 percent of the disciplinary hearings for nurses within the state were related to substance abuse.[16] These are often very bright, hard-working practitioners who are ambitious and hold responsible positions. What is to be done when you find that a colleague is impaired? Impaired colleagues place clients at risk. The nature of substance abuse is such that even fine practitioners begin to experience behavioral difficulties such as absenteeism, illogical decision making, and excessive errors. Guided by the principle of nonmaleficence, the question that must be faced is not whether the practitioner has a duty to intervene, but rather the manner of the intervention.

The normal questions that one asks oneself are:

- Do I have all the facts?
- Am I sure?
- Is this my problem?
- Who am I to judge?
- Should I ignore the situation?
- What might it cost me if I confront the situation?
- Is it worth the trouble?

The problem with these rather legitimate and normal questions is that they often do not lead to the correct answer. It is too easy to say "How terrible! I'm sorry about ________, but it's not my job to tell anyone." The problem with this approach is that it is very enabling and does not assist the impaired provider. Equally problematic is the muttering to friends about "poor old Joe," as that is not effective in stopping the behavior and is destructive to the individual's reputation and to the reputation of all health care specialists.

Suppose you saw a colleague administer only one-half of a dose of narcotic, place the syringe in his pocket, and leave for the restroom. To make the case clearer, suppose you later found a bloody, empty syringe in the restroom wastebasket. What should you do? What if you confronted the individual and he denied the whole thing? Addicted individuals often seem to have an infinite supply of rationalizations, prevarications, and subterfuges to convince others that the truth is untrue. It is hard to imagine a more unpleasant task than confronting a colleague about substance abuse, but—pleasant or no—the health care provider must be confronted and be made to seek effective assistance. Where possible, it is best that the individual be encouraged to seek the help independently; where not possible, help must still be obtained in order to protect the patients and salvage the practitioner. Regardless of how the process goes, the basic elements are that the practitioner receives effective help and that those with knowledge of the situation treat the impaired colleague humanely, as we would any patient who needed our assistance.

CASE STUDY

Doctors and Nurses Should Be Randomly Tested for Drugs and Alcohol!

In a presentation to the New York Society of Addiction Medicine, noted bio-ethicist, Dr. Arthur Caplan, argued that doctors and nurses should undergo random drug testing. He stated, "The problem is particularly serious among doctors and nurses in anesthesiology—the more you are around drugs, with easy access to pain medications, the bigger the risk." If drug testing is common for airplane pilots, train conductors, and truck drivers, why not doctors and nurses? Caplan states, "You have to assume some medical errors are due to drug or alcohol abuse."

Caplan suggested the consequences for drug or alcohol abuse would vary according to circumstances, requiring that on the first offense the doctor or nurse would go into a mandatory treatment program, their license to practice suspended until they remained drug or alcohol free for a designated period of time. Those with repeated offenses, especially those abusing opiates, may need to have their license revoked.[17]

1. Do you agree or disagree with the Caplan proposal? Defend your answer.
2. Are his suggested consequences reasonable?
3. Would you include other allied health specialties that provide direct patient care?
4. Who should monitor this?

HEALTH CARE PROVISION IN A MULTICULTURAL SOCIETY

Americans have a difficult time agreeing on whether the nation should be described as a melting pot, where new groups are blended into the dominant culture, or a tossed salad, with each of the elements of society remaining distinct but somehow adding zest to the whole. Whatever model, whether melting pot or salad, the underlying truth is that we are a nation of immigrants, truly a multicultural society. Most Americans, even those who are not immigrants themselves, have families that came from elsewhere. Only Native Americans, the Aleuts, and the Inuit people (Eskimos) are considered native.

CASE STUDY

"Wo Bu Dong" I Don't Understand!

You are vacationing in a non-Western country. You are suddenly taken ill and admitted to the local hospital. You now wish that you had bought the travel insurance, which would have allowed you to be immediately transported home. Although the hospital appears modern and has the reputation for a reasonable standard of care, you may have the following concerns:

- What is everyone saying?
- What is my diagnosis? Prognosis?
- How does the system work here?
- Will I be able to make myself understood?
- Will I be able to get what I need?
- Can I trust them with my life?

Now imagine that this is one of your patients—after all we pride ourselves in being a multicultural nation. Do you have a professional obligation to bridge these gaps in understanding and find ways to assure this patient? What things might you do?

Since the 1950s there has been an explosion of group consciousness in the United States as many of the ethnic groups have sought to find and identify with their roots. It is the most American of all phenomena to ask yourself what it means to be a ________ American. As an example, it is hard to imagine a Chinese person in the People's Republic of China asking themselves what it means to be Chinese. They know. This rejuvenation of ethnic identity in the United States has often served to isolate and alienate individual groups. We are truly a universal nation, a pluralistic society, with competing ideas regarding basic issues such as the meaning of health and illness. This distinct feature of American culture has interesting and

challenging implications for health care practice. Somehow we must not only understand that there are differences, but also confront them honestly if we are to serve the patients who make their way into our care.

As health care providers we are generally socialized into the cultures of our particular practices. This professional socialization teaches each practitioner a set of beliefs, habits, practices, likes, dislikes, and acceptable norms. This new set of learned information may or may not conform to the traditions of the individual prior to entering practice. As practitioners become more and more socialized into the provider culture, they often become further removed from the population at large in regard to its understanding of issues involving health and illness. It is this movement away from the population at large that often leads patients to complain that health care providers are speaking a foreign language. This is exacerbated when the health care provider is actually speaking a foreign language. But language is not the real issue; often the problem is that in the socialization to our particular practice, we become for all purposes a foreign culture or ethnic group to the patients we serve.

Most health care practitioners in the United States adhere rigidly to the Western system of health care delivery and often disdain any ideas of prevention and healing that fall outside the accepted scientifically proved methods. The following response from a family practice physician regarding the use of a particular herbal medicine sums up this attitude, "If it had any scientific validity, we [American physicians] would be dispensing it."

Health care providers are often not only ethnocentric but also xenophobic when it comes to practice. The only types of healers or practitioners that we tolerate are those who have been educated and certified by the provider culture. What happens to the patient with a different belief system from the practitioner in regard to illness and treatment? Are practitioners truly able to meet the needs of patients if they do not understand how the patient views health, illness, or treatment?

CASE STUDY

Stop! Before You Continue, I Want to See a Medicine Man

You are working in an emergency room near the Navaho reservation, examining a 40-year-old Native American who has injured his arm at his work site. Just by viewing him, the arm appears broken. The man requests that you call a medicine man before you do anything further.

1. Does his coming to the emergency room provide you with an "implied informed consent" to treat?
2. Would you move forward with the X-rays?
3. If possible should you find a medicine man?

Individuals, who find themselves in transition from one setting to another, where one fails to understand the basic cues of social intercourse, are susceptible to the high stress malady known as **culture shock**. What often happens in this situation is that a communication barrier is raised, which often is described as being either a problem patient or an uncommunicative one. Consider, for instance, the patient with a heart condition who is restricted to bed. Although he is told to remain in bed and appears to understand, he is found several times a day standing and gazing out his window. The nurses complain to each other that the patient is uncooperative. The patient, a devout Muslim who by faith is required to pray several times a day facing in a particular direction, feels that the religious priority overcomes the requirement of bedrest. Understanding and changing the bed position so it faced in the required direction might have solved what unfortunately became a breakdown in communication in which all involved, especially the patient, lost. As a nation of immigrants we have patients who face these challenges every day. Hospitals are daunting places, even for people with medical backgrounds. Often we think that our communication problems are the differences in the patient's language. Yet this is only one of the barriers, and perhaps not even the most important. The question becomes whether we as practitioners are standing in the way of their getting well. The influence of cultural factors on the response of patients and families to ill health and hospital care plans cannot be underestimated. Always remember that quality care is a lot more than diagnostics, procedures, and drug administration.

- Why is it important to respect the cultural beliefs of our patients?
- What basic principles underpin our need to be culturally sensitive?
- Where would you go to discover well known sets of beliefs?
- What if the request based on culture is harmful to the patient?

A DUTY TO TREAT

Despite its terrifying reputation, Ebola has been a rare disease, emerging every few years, killing a few dozen victims in remote African villages. Since first identified in 1976, the virus has remained essentially stable with no signs of mutation that would make it more easily transferable. It is only contracted from close contact with an infected person's body fluids. Figure 7-1 lists the symptoms of Ebola.[18]

The most recent and most devastating Ebola outbreak dates back to December 2013, in a forested area of Guinea near the border with Liberia and Sierra Leone. Travelers took it across the border and, by late March 2014, Liberia had reported eight suspected cases and Sierra Leone six. As of August 2015, there were 28,041 cases and 11, 302 deaths worldwide making this the worst ever Ebola outbreak. The vast majority of these cases and deaths occurred in the same three countries.

Early Symptoms

Symptoms can appear from 2 to 21 days after exposure.

- Fever
- Headache
- Diarrhea
- Vomiting
- Stomach pain
- Unexplained bleeding or bruising
- Muscle pain

FIGURE 7-1 Ebola Symptoms
Source: Centers for Disease Control and Prevention

The World Health Organization reports that each country now has enough treatment beds to be able to isolate and treat patients with Ebola, and to bury everyone known to have died of the disease. The rate at which a disease gives rise to subsequent cases is what epidemiologists call R0, which is an important variable in the spread of Ebola. For easily transmitted diseases R0 can be high; for measles it is 18. Ebola is much harder to catch: estimates of R0 in different parts of the outbreak range from 1.5 to 2.2. The higher the R0 above 1 the worse the news. However, the very high mortality rate of the disease in Africa, estimated at around 60 percent in this outbreak, means that Ebola can quickly claim more lives than other, more established killers, even with a relatively low RO.

The key to the Ebola statistics is the inadequacies of the health care systems in the three most-affected countries and helps explain how the Ebola outbreak grew so rapidly. The United States spends over $8,000 per person on health care; for Sierra Leone, the figure is just under $300. The United States has 245 doctors per 100,000 people; Guinea has ten. The vulnerability of health care workers to Ebola and their relatively small numbers in African countries is doubly tragic: as of August 23, 2015, there had been 881 cases among medical staff in the three West African countries and 512 deaths.

The United States was slow to respond to the epidemic even as it appeared to be spiraling out of control in Africa. In mid-2014 the president pledged $700 million, and 3,000 troops to shore up the buckling health care systems in the affected countries. For many Americans, the idea of an infected individual getting on an airplane or boat was all that was necessary to create a global crisis on the par with the plagues of history. Harris Poll/Health Day in October 2014 showed great concern among Americans with 27 percent considering the Ebola virus to be a major threat to the United States. One in four people who had holiday or business travel plans said that they were planning to cancel or defer their travel because of concerns.[19] Consider the following case study to explore the implications of personal and professional values and duties.

As it turned out, the mortality rate of Ebola depended on where patients were treated. Of the confirmed cases in the United States—mostly a mix of medical volunteers who returned from Africa, and the two nurses who caught the disease treating them—there has been one fatality. In the case of the one fatality, a Liberian national, his treatment was delayed because of a misdiagnosis when he initially sought help in a hospital.

IN THE NEWS

Personal Values, Professional Duties

After spending a month working with sick and dying Ebola patients in West Africa, Nurse Kaci Hickox returned to the United States. When she arrived in New Jersey, she was placed (imprisoned/her view) in a quarantine unit. In that she had never tested positive for the disease, she refused the quarantine and was released. Arriving in Maine officials there ordered her to stay at home and self-monitor for symptoms for the 21-day incubation period of the disease. She refused to remain at home and the next day went bike riding around the community with a friend. Because of her experience in Africa, Kaci knew that as long as she didn't exhibit symptoms she was not contagious and posed no danger to community health—but within the incubation period she was still a potential patient. Clearly she felt that the officials were overreacting, and that as a citizen she had a right to personal autonomy and self-determination.[20]

1. Does the fact that she was a nurse create an obligation for her to remain at home away from the community to reassure the public even if she believes there was little or no risk whatsoever of spreading the potentially fatal disease?
2. Does it matter that she was on vacation and not performing nurse duties?
3. Is this a case where personal values and professional obligations conflict?
4. Are there times when the impact on the many (even if the possibility of harm is slight) outweighs the impact on the one?

In comparison to Africa, American hospitals possess superior facilities, staffing, and equipment. When patients began to suffer from severe vomiting and diarrhea, the loss of fluids—up to 5 gallons per day—these were replenished by IV fluids to prevent organ failure and shock. Electrolyte and mineral levels were monitored and adjusted. American physicians also have access to industrial-sized autoclaves to sterilize waste, and experimental antiviral drugs and blood serum from patients who've developed antibodies to Eboli. The disease is very scary, but thankfully in the United States the number of cases is very small, with a survival rate of 80 percent. Insurance companies estimated that treating an Ebola patient would cost up to $25,000 per day.

The ethical problems associated with an epidemic are many and cut to the very heart of what it means to be a health care practitioner. The fact that Ebola in Africa had a high mortality rate, and no known cure or preventive vaccine, made it a disease that caused rethinking of basic issues.

- What does our culture require of us in regard to Ebola patients in other countries?
- In a health care system already overburdened with the costs of health care, what resources should be allocated to international health care assistance?

- Should we stop all travel to and from the epidemic area to the United States?
- Do health care practitioners have a duty to treat? What is an acceptable risk for health care professionals?

While we are not required to risk our lives in futile and perhaps dangerous gestures, under most situations that is not what we faced with this patient group. This was not a disease that is easily transferred from one to another without contact with body fluids. None of the family living with the Liberian national, who died in the United States, contracted the disease. So this concern would not, in general, represent an acceptable rationale for refusing to treat but would create an obligation on the part of health care workers to take appropriate protective actions.

The American Nursing Association (ANA) Committee on Ethics offers some useful guidelines regarding the decision as to whether the practitioner has a **moral duty** to treat or whether the decision is left as a **moral option**. The four fundamental criteria are:[21]

1. The patient is at significant risk of harm, loss, or damage if the practitioner does not assist.
2. The practitioner's intervention or care is directly relevant to preventing harm.
3. The practitioner's care will probably prevent harm, loss, or damage to the patient.
4. The benefit the patient will gain outweighs any harm the practitioner might incur and does not present more than a minimal risk to the health care provider.

If the practitioner can answer yes to all four criteria, it would seem that a moral duty to treat would exist under the principle of beneficence. If, however, the circumstances place the practitioner in such a position that all criteria could not be answered with yes, then the decision to treat would become a moral option rather than a duty. An example of this might be an answer of no for the crucial fourth criterion, in a case in which an EMS practitioner directed to a home, finds a patient exhibiting the signs of Ebola, and no infection control systems are in place. Treatment would not be mandated by duty.

INSTITUTIONAL ETHICS COMMITTEE

One of the important issues of role duty is the obligation that each practitioner has in maintaining not only a high level of technical practice but also maintaining the common field in which all health specialists practice. There is a great and deep well of respect that is afforded each practitioner, which has been filled by those who have practiced before us. Our conduct in representing our specialties, the humanity of our service to the patients, the respect we afford other practitioners, and the service we provide to the community are important aspects of a professional career, and it is these activities that maintain the area of common practice that surrounds us.

One growing area of potential service is the opportunity to serve as a member of an institutional ethics committee. An institutional ethics committee (IEC) can be defined as an interdisciplinary body of health care providers, community representatives, and nonmedical professionals who address ethical questions within the health care institution, especially on the care of patients.

The impetus for such a committee came from the high profile cases involving Karen Ann Quinlan and Baby Doe.[22] The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research advocated research into ethics committees.[23]

Often ethics committees are seen as alternatives to court litigation. Health care providers were struggling with new issues that came as the result of previously unimagined life-saving medical technology and team medicine in which literally hundreds of practitioners were responsible for some aspect of the care. The committees were seen as a way to safeguard the patient's interests by serving on a consultative basis to analyze ethical dilemmas; educate health care providers, patients, and families; and guide hospital policy. Figure 7-2 lists the most common functions associated with ethics committees. Note that decision making is not one of the functions listed. These committees play an advisory role.

In 1992, the Joint Commission (JC), the accrediting agency for hospitals and other health care organizations, required the establishment of organizational mechanisms for addressing conflicts within the health care setting. In most organizations covered by the Joint Commission this has meant the development of ethics committees.[24] The modern committee is often a multidisciplinary group that includes physicians, nurses, social workers, philosophers, laypersons, lawyers, administrators, and religious leaders. In recent years, health care providers have become increasingly sophisticated regarding ethical issues and processes through readings, conferences,

- Policy and procedure development
- Educational role
- Case consultant
- Retrospective case review

FIGURE 7-2 Common Functions of Ethics Committees

seminars, and so forth. In that ethical training is increasing in all health care programs, in the future more allied health and nursing professionals will be prepared to participate in IECs.

Often the philosophy of the committee reflects the nature of the institution. For example, a Catholic hospital will generally reflect the tenets of that faith. The refinements in policies concerning brain death determinations, do not resuscitate (DNR) orders, and patient rights have been a great strength of the ethics committees. Given our movement toward health care reform and the use of market forces to assist in cost containment, it is likely that new areas of policy will include issues involving health care access, organ procurement, rights of the incompetent elderly patient, and problems of premature discharge.

CONCLUSION

We are in a time of great change for American health care. Rapid technological and social change has pushed the frontiers of health into uncharted territory. Many of the legal and ethical issues faced by health care providers are new. To make matters more complicated, this is also a time of legislative reform to the health care system where at times it seems the only thing that is truly stable is change.

This is a litigious age. Outpatient populations have come to expect miracles that cannot always be delivered. Practitioners at times find themselves seemingly between two forces: unhappy patients, aggrieved relatives, and their lawyers versus the risk management departments, other health care providers, clinical institutions, and insurance companies. Practitioners are expected to conduct themselves in a manner that protects the patients and the institutions they serve.

This chapter has dealt with several functions that can be listed under the headings of "small ethics." While they do not deal with the great life-and-death issues such as euthanasia, justice, or withholding or withdrawing life support, they are the daily stuff of modern practice. They come to us as a function of our role duty and are the price we pay for being professionals. As practitioners of health professions we have an obligation to our patients, our colleagues, and our professions to perform these necessary, albeit unpleasant, gatekeeping tasks.

KEY CONCEPTS

- Self-regulation is one of the key elements of our profession. Professional codes of ethics are important documents in the process of self-regulation.
- Disparagement and improper bad-mouthing of other health care providers serves neither our profession nor our patients.
- Care must be taken to manage the therapeutic relationship so that patient exploitation is avoided.

- Under no circumstances may the practitioner place his financial interests above the welfare of his patients. The primary objective of the health professions is to render service to humanity. Reward or financial gain is a subordinate consideration.
- Gaming the system even for the benefit of the patient is a suspect practice that harms the health professions.
- All clinicians must understand and remain within the constraints of their professional practice act.
- Gatekeeping within role duty and fidelity requires that individual practitioners be responsible not only for their standard of practice but work to protect the community, patients, and our specialties from abuses of other practitioners.
- Often the lack of cultural cues within the health care setting is severe enough for non-Western patients as to create culture shock and interfere with the ability of the patient to benefit fully from the service.
- The principles of beneficence, nonmaleficence, role duty, and justice provide an ethical and professional imperative for health care providers to build bridges of understanding that allow successful practice among those with a different view of health, illness, and appropriate practice.

REVIEW EXERCISES

A. On an ethical basis, going beyond your scope of practice, having sexual relations with patients, and self-referrals are problems. Write a short paragraph for each of these practices using a legitimate moral rationale (excepting "that's how I feel") indicating why these practices do harm to the professions, the practitioners, and the patients we serve.

1. Going beyond scope of practice
2. Sexual relations with patients
3. Self-referral

B. In the article (found in the chapter) regarding inappropriate resuscitation, the therapist was attempting to bring about legitimate change in practice. What he wanted was the establishment of guidelines such as:[25]

- DNR orders should be documented in the written medical record.
- DNR orders should specify the exact nature of the treatment to be withheld.
- Patients, when they are able, should participate in DNR decisions. Their involvement and wishes should be documented in the medical record.

- Decisions to withhold CPR should be discussed with the health care team.
- DNR status should be reviewed on a regular basis.
- DNR is not equivalent to medical or psychological abandonment.

With the previous guidelines in mind, first underline the sections within the article that appear inflammatory and devoid of collegiality. Second, rewrite the article so that it is less inflammatory and more persuasive. Third, decide upon a plan (Who, What, Where, Why, When) on how you are going to go about bringing your ideas in regard to changing the resuscitation policy so that it comes into line with the previous guidelines.

C. The story in regard to the nursing educator from Idaho was essentially true. Indicate whether you think the nurse or the Board of Nursing was correct. In deciding, use the decision-making model proposed by M. C. Silva:[26]

1. Gather the facts.
2. Identify the dilemma in concrete terms.
3. Explore all options and rules or principles governing each option.
4. Make a decision, and be prepared to reflect on the decision.

D. Use the following decision-making format for the following case involving an impaired coworker. (Take each step as a separate exercise and work through the problem.)

Steps to Problem Solving

1. Problem sensing—gather information, review facts.
2. Formulate and state the problem.
3. List all solutions of initial credibility.
4. Evaluate each solution in terms of its consequences for the individuals involved.
5. Evaluate solutions in terms of upholding or sacrificing the basic principles of health care.
6. Select the solution with the best consequences and least sacrifice of basic ethical principles.
7. Prepare a defense for your choice.

You and Ben have been friends since you met in physical therapy school. Following graduation you both took positions within a local clinic. Lately Ben has been going through a difficult and emotional divorce. At work he has begun to act erratic, often talking a mile a minute and at other times appearing withdrawn and quiet. You wonder if he has begun to abuse drugs.

One day Ben confirms your fears when he tells you that he needs to take pills to go to sleep and that he takes others in the day to stay awake. He feels that he is not abusing the drugs in that he has prescriptions for all of them provided by a variety of physician friends. He asks you as his friend not to tell anyone, and tells you that he will be able to get a handle on his problems once the divorce is settled.

The next morning during report, Ben appears to fall asleep. After report, your supervisor, who knows that you and Ben are friends, comes to you and asks, "What is the matter with Ben?" How do you respond?

E. Several traditional populations do not donate organs at the same rate as the majority population in the United States. There are many reasons for this, including in some cases a cultural need for body integrity following death. Given that these groups have decided not to provide organs, should they receive organs on the same basis as groups that more readily donate them? Defend your answer.

F. Answer the following questions related to the duty to treat.

1. If the nurse attending the patient were herself immune suppressed, would this be enough to move the duty to treat an HIV-infected patient to the moral option of treating or not treating?
2. The United States has currently pledged several hundred million dollars toward the international fight against Ebola and AIDS. Many in the world have criticized us for not giving more. What do you think is our obligation?

NOTES

1. Michael Bayles, *Professional Ethics* (Belmont, CA: Wadsworth Inc., 1981).
2. James Whitacre, "Ole Nincompoop Says: Help Stamp Out Inappropriate Resuscitation," *Newsletter of the Missouri Society for Respiratory Therapy* (1980): 11–12.
3. Alen Levinovitz, "Dr. Oz and the Pathology of Open-Mindedness," *The Atlantic*, April 23, 2015.
4. Jeremy Sugarman, *Ethics in Primary Care* (New York: McGraw-Hill, 2000).
5. Catherine Regis, " Physicians gaming the system: modern-day Robin Hood?" (Pdf). *Health Law Review* (2005): 19-24.
6. E. H. Morreim, "Gaming the System, Dodging the Rules," *Archives of Internal Medicine* 151 (1991): 443-447.
7. Council on Ethical and Judicial Affairs, *Code of Medical Ethics: Current Opinions and Annotations* (Chicago: American Medical Association, 1996).
8. Ayla Ellison, "Halifax Settled FCA Allegations for $85M, Announces DOJ," *Becker's Hospital Review*, March 17, 2014, http://www.beckershospitalreview.com/legal-regulatory-issues/halifax-settled-fca-allegations-for-85m-announces-doj.html.