



*An Ethical Force Program™ Consensus Report*

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## **Improving Communication—Improving Care**

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How health care organizations can ensure effective, patient-centered communication with people from diverse populations

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# APPENDIX B

## Ethics and Patient-Centered Communication

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## Appendix B: Ethics and Patient-Centered Communication

Health care organizations hold unique ethical obligations. Though profitability may be an important motivation, health care organizations are expected to strive to meet the health care needs of the communities they serve (Pijneneburg and Gordijn 2005, Wilmot 2000, Emanuel 2000). This expectation creates a social covenant between health care organizations and their communities. Sometimes the covenant is explicit, such as when a hospital's mission statement contains specific goals for meeting patients' communication and other needs, and sometimes it is implied. One tool that health care organizations use to fulfill their social covenants and meet their ethical obligations is patient-centered communication.

Patient-centered communication is communication that is respectful of and responsive to patients' preferences, needs and values. Any communication that affects patients can be patient-centered, including oral, written and nonverbal communications between patients and practitioners, patients and health care organizations, and between and among health care practitioners and health care organizations. Patient-centered communication is vital for health care organizations to provide ethical, high-quality care. The ethical importance of patient-centered communication is reflected in several professional codes, guidelines, and standards for health care organizations. This examination of patient-centered communication and ethics is complemented by business and other related arguments for patient-centered communication (*see Appendix C: The "Case"*).

The documents used here to explore ethics and patient-centered communication include:

- The Joint Commission on Accreditation of Healthcare Organizations Standards for Hospitals, Ambulatory, Behavioral Health, Long Term Care, and Home Care (Joint Commission 2004)
- The American Hospital Association "Ethical Conduct for Health Care Institutions" (AHA 1992)
- The American Medical Association "Principles of Medical Ethics" (AMA 2004)
- The American Nurses Association "Code of Ethics for Nurses" (ANA 2001)
- The American Pharmacists Association "Code of Ethics for Pharmacists" (APhA 1994)
- The Institute of Medicine Report, "Crossing the Quality Chasm: A New Health System for the 21st Century" (IOM 2001)
- The Institute of Medicine Report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care" (IOM 2003)
- The Office of Minority Health "National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care" (U.S. DHHS OMH 2001)

These documents were created by a wide variety of groups representing various health-related interests. Ideas about ethics in health care that appear across all these documents are likely to represent an ethical consensus among health care organizations.

These codes, guidelines and standards each argue that health care organizations and providers have specific ethical obligations related to patient-centered communication. These ethical obligations that relate to patient-centered communication fit into three broad themes:

- Health care organizations must maintain and protect the autonomy of health care users.
- Health care organizations must assure quality care.
- Health care organizations must maintain equity among health care users.

None of these ethical obligations can be fully achieved without patient-centered communication.

The first ethical obligation, to maintain the autonomy of health care users, is central to any ethical examination of patient-centered communication. Each of the documents described here addresses the importance of patient autonomy in some way. According to the American Hospital Association "Ethical Conduct for Health Care Institutions," "policies and practices must respect and promote the patient's responsibility for decision making" (AHA 1992). The "Code of Ethics for Nurses" requires that nurses respect patient self-determination and autonomy (ANA 2001). The American Medical Association "Principles of Medical Ethics" and the "Code of Ethics for Pharmacists," similarly argue that physicians and pharma-

cists must respect patients' dignity and autonomy (AMA 2004; APhA 1994). "Crossing the Quality Chasm" suggests that the patient must be the "source of control" in order to improve the quality of care in the United States (IOM 2001).

There is agreement within the health care system that maintaining health care users' autonomy and recognizing autonomous patients' preferences, needs and values is vital to providing ethical health care. This ethical obligation cannot be met without patient-centered communication. Communication that is respectful of and responsive to health care users' preferences, needs and values is the mechanism that health care practitioners use to discover patients' preferences so that they may act on them. Without patient-centered communication, patients and clients are taken out of the loop, leaving practitioners to assume or guess their needs and preferences. In such a situation, autonomy is simply impossible.

Several of the documents above focus on the ethical obligation to maintain patients' autonomy with specific regard to health care users' cultures and linguistic backgrounds. The American Hospital Association "Ethical Conduct for Health Care Institutions" states that "health care institutions should assure that the psychological, social, spiritual and physical needs and cultural beliefs and practices of patients and families are respected" (AHA 1992). The CLAS standards address issues of language and communication directly, stating that "Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and preferred language" (U.S. DHHS OMH 2001). The Institute of Medicine Report, *Unequal Treatment*, argues that health care providers must be educated to respect and interact with patients from any culture (IOM 2003). It is not possible for a health care organization or a health care practitioner to respect and accommodate patients' cultural and linguistic background without communicating with them in a way that is responsive to their preferences, needs and values.

Of special note is that health care organizations must take extra care when communicating with individuals from cultures in which autonomy itself is not as strong a value as it tends to be in Western cultures. In some cultures (and in some families in every culture) health care decisions are not so much made autonomously by individual patients as they are made collectively within the family. Health care organizations should be alert to recognize and honor such

cultural or personal preferences. To do so is not disrespectful of patient autonomy; it is within the rights of autonomous persons to share decision-making authority about their health care with anyone they choose—including their family, doctor, religious leader or simply a friend.

The second ethical obligation of health care organizations, reflected in the codes, guidelines and standards examined here, is that health care organizations must assure quality care. Each of the documents explicitly addresses obligations regarding quality and argues that health care organizations must provide all health care users with care that meets recognized quality standards. Patient-centered communication is at the heart of this ethical obligation because it is vital to assuring and improving quality for communication-vulnerable groups (*data to support this assertion are reviewed in Appendix C: The "Case"*). The use of patient-centered communication can expose areas where communication-vulnerable groups receive low-quality care and allow practitioners to find ways to improve their care. Furthermore, if health care organizations and practitioners communicate with patients and clients in a way that is responsive to their preferences, needs, beliefs and values, patients are more likely to receive appropriate care and are more likely to return for more care in the future. Patient-centered communication increases trust in the health care system and opens it to traditionally underserved communities. This may dramatically improve the access to and quality of the care members of these communities receive.

The third ethical obligation of health care organizations, to maintain equity among health care users, is also well reflected in the documents examined here. The "Code of Ethics for Pharmacists" states that "when health resources are allocated, a pharmacist is fair and equitable, balancing the needs of patients and society" (APhA 1994). The Institute of Medicine report on quality states that health care organizations should be equitable, "providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status" (IOM 2001). Communication barriers, whether culture, language or literacy-related, are personal characteristics that can vary dramatically from patient to patient. Patient-centered communication is a method that health care organizations can use to ensure equity among individuals facing varying communication challenges. For instance, to communicate effectively with practitioners, health care users from communication-vulnerable groups often require interpretation or documents that have been translated into clear and simple language. Without these

types of patient-centered communication services and interventions, these patients will be more likely to experience communication gaps. Communication gaps include when a practitioner misunderstands or discounts specific concerns about a treatment or medication, when an informed consent discussion does not achieve full informed consent, or when a patient leaves a health care encounter without understanding treatment, follow-up, or medication instructions. Without patient-centered communication, equity is not possible. This is because individuals from communication-vulnerable groups can experience communication gaps, which might result in their receiving a lower quality of care than those from other, less vulnerable groups.

This set of ethical responsibilities—to promote and respect autonomy, assure quality of care, and deliver equitable care—establishes an ethical case for the importance of patient-centered communication in health care. It is no accident that these responsibilities are in line with the basic ethical principles laid out in the Belmont Report on the ethical conduct of research on human subjects (The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1979). These core ethical principles, usually spelled out as autonomy, beneficence and justice, form a comprehensive, consensus-based ethical framework for how to care for any person in a situation of vulnerability.

As clear and consistent as these three responsibilities may seem, there are times when patient-centered communication can uncover previously unnoticed ethical dilemmas. This can be especially problematic when the three responsibilities examined here come into conflict with each other. For instance, through patient-centered communication, a physician might discover that an individual holds a value or belief that is causing him/her to make decisions that might have a negative impact on his/her health (such as a personal belief in faith healing that is leading to nonadherence to prescribed medications). In this situation, the responsibility to maintain individuals' autonomy comes into conflict with the responsibility to provide quality care. Should the physician respect the patient's autonomy and allow him or her to make a decision that could result in a poor health outcome, or attempt to persuade, or coerce, the patient into taking a different course, perhaps sacrificing some degree of autonomy? In most cases, physicians can educate such patients on the facts of a condition, clearing up any misconceptions; but if the patient's decision rests on values that differ from the

physician's, not a misunderstanding, then autonomy must generally be respected.

Resource limits also create ethical dilemmas in addressing the communication needs of vulnerable populations. As a result of resource limits, the responsibility to provide patient-centered communication to all health care users (equity) can come into conflict with the responsibility to assure a high quality of care. As an extreme example, a health care organization might decide to use its resources only to serve those health care users with whom practitioners can easily communicate. As a result, the patients served might receive high-quality care, but at the expense of having some patients locked out of the system (i.e., inequity). However, most health care organizations have a responsibility to serve all members of their communities, so they cannot pick and choose whom to serve based on communication skills. In other words, health care organizations' ethical responsibilities require them to meet vulnerable populations' needs, even if the organization must commit additional resources to do so.

So how much of an organization's resources should be devoted to meeting the communication needs of vulnerable populations? When resources spent on improving communication come from a limited pool, arguments over balancing communication needs with other needs are inevitable. Indeed, limited resources can at times cause communication-vulnerable populations to receive lower-quality care than other groups. But this inequity in quality of care is a reason that organizations should seek ways to provide patient-centered communication effectively and efficiently, not an argument for denying communication-vulnerable groups access to care. In short, in the face of resource limits, ethical health care organizations must make a good-faith effort to provide equal access to high-quality health care for all populations.

Until this point, we have examined ethical arguments for patient-centered communication that are reflected in eight prominent documents that discuss the ethical responsibilities of health care organizations. This strategy relies largely upon the ethical method of principlism, establishing an ethical basis for action based on specific rules, or principles (e.g., autonomy, beneficence and justice). But principlism is just one approach to moral philosophy. Other ethical and philosophical movements and methods, including utilitarianism and deontology, can provide additional ethical bases for patient-centered communication.

Very briefly, according to utilitarianism the right action (or practice) is the one, out of the available possibilities, that maximizes aggregate happiness, or “utility.” Through effective communication, health care organizations will be better able to ascertain the preferences, needs and values of individuals and populations, and will consequently be able to provide treatment that is consistent with these preferences, needs and values. Patients will derive more satisfaction from treatments that are consistent with their preferences, needs and values than from treatments inconsistent with these. Put simply, through patient-centered communication health care organizations make the individuals and populations they serve happier (*and healthier*, Appendix C: *The “Case”*). Those who have the most to gain from patient-centered communication are those for whom communication is most difficult to begin with—suggesting that special efforts to address the needs of these populations will bring the most additional “utility.” As discussed in Appendix A, health care organizations can also benefit from patient-centered communication in a wide variety of ways. Individual patients, patient populations, and health care organizations all can derive utility from patient-centered communication. Finally, it is reasonable to suggest that widespread progress in patient-centered communication could improve the way that society views health care and lessen any public mistrust or cynicism about health care systems. Taken together, these factors all suggest that utilitarianism supports efforts to promote patient-centered communication, especially efforts to address the communication needs of vulnerable populations.

Deontology is the study of rights and duties. Under deontology, rights and duties cannot be violated even if doing so would contribute to aggregate happiness. There are many versions of deontology, but most of these share a central core that will be familiar from the discussion of principles above. Owing to Immanuel Kant, most deontological ethical theories hold that all humans are morally required to respect the autonomy of other persons (Reich 1995). So a central question that deontology poses with regard to patient-centered communication is: what is the relationship between patient-centered communication and autonomy? If patient-centered communication is sensitive to autonomy, then it is a moral good. (Or, alternatively, if the absence of patient-centered communication interferes with

autonomy, then patient-centered communication must be considered a moral good.) We have already established that patient-centered communication is vital to maintain patient autonomy. Thus, patient-centered communication is a moral good for the deontologist.

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## Conclusion

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These extremely brief summaries of a principlist approach, a utilitarian approach and a deontological approach to the ethics of patient-centered communication are remarkable for the degree to which all support its ethical importance. Clearly patient-centered communication is vital to ethical health care. The principlist argument, in particular, is reflected in a number of key ethical codes, guidelines, and standards that strongly support the ethical consensus that health care organization must take steps to foster and promote patient-centered care.



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## References

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American Hospital Association (AHA). *AHA Management Advisory: Ethical Conduct for Health Care Institutions*. 1992. [www.hospitalconnect.com/aha/resource\\_center/resource/resource\\_ethics.html](http://www.hospitalconnect.com/aha/resource_center/resource/resource_ethics.html) (accessed Mar 3, 2006).

American Medical Association (AMA). *Code of Medical Ethics: Current Opinions with Annotations 2004-2005* ed. Chicago, IL: American Medical Association; 2004a. [www.ama-assn.org/ama/pub/category/2498.html](http://www.ama-assn.org/ama/pub/category/2498.html) (accessed Mar 7, 2006).

American Nurses Association (ANA). *Code of Ethics for Nurses*. 2001.

American Pharmacists Association (APhA). *Code of Ethics for Pharmacists*. 1994.

Emanuel LL. Ethics and the Structures of Healthcare. *Cambridge Quarterly of Healthcare Ethics*. 2000;9:151-168.

Reich, Warren Thomas, Ed. Ethics: Normative Ethical Theories. *Encyclopedia of Bioethics*. Vol. 2. New York, NY: MacMillan; 1995; 736-747.

Institute of Medicine Committee on Quality of Health Care in America (IOM). *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press; 2001.

Institute of Medicine Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care (IOM). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: National Academy Press; 2003.

The Joint Commission on Accreditation of Healthcare Organizations (Joint Commission). *The Joint Commission Standards for Hospitals, Ambulatory, Behavioral Health, Long Term Care, and Home Care*. 2004.

The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research*. 1979.

Pijnenburg MA, Gordijn B. Identity and moral responsibility of healthcare organizations. *Theor Med Bioeth*. 2005;26(2):141-60.

U.S. Department of Health and Human Services' Office of Minority Health (U.S. DHHS OMH). Final Report: National Standards for Culturally and Linguistically Appropriate Services in Health Care. Washington, DC: OCR; Mar 2001. [www.omhrc.gov/templates/content.aspx?ID=87](http://www.omhrc.gov/templates/content.aspx?ID=87) (accessed Mar 3, 2006).

Wilmot S. Corporate Moral Responsibility in Health Care. *Med Health Care Philos*. 2000;3(2):139-146.