

Ethics, Legal Considerations, and Professionalism

Learning Objectives

At the conclusion of this chapter, you will be able to:

- Discuss reasons why a study of professional behavior is important to the limited x-ray machine operator
- Apply ethical concepts to typical situations that arise in the health care setting
- Explain the rationale for confidentiality of professional communications and list precautions for maintaining confidentiality
- Demonstrate respect for patient rights that the limited operator is responsible for protecting
- List specific acts of misconduct and malpractice that could occur in the practice of radiography and describe the most frequent circumstances that cause patients to initiate litigation
- List aspects of self-care that demonstrate responsible behavior by the limited operator
- Demonstrate effective communication skills, including listening skills, nonverbal skills, and validation of communication; discriminate between assumed and validated statements
- Suggest positive strategies for both verbal and nonverbal communication with patients who have hearing and/or visual impairments and with patients from other cultures
- Demonstrate communication strategies that promote teamwork in the workplace
- Demonstrate professional skills in handling messages sent and received on paper and by telephone, voice mail, and fax
- Demonstrate the use of patient charts for both obtaining and recording information; state the essential characteristics of good medical records
- Explain requirements for maintaining radiographic images and procedures for lending them

Key Terms

aggressive	intentional misconduct
assault	invasion of privacy
assertive	libel
battery	malpractice
chart	morals
charting	negligence
defamation of character	reasonably prudent person
empathy	<i>respondeat superior</i>
ethics	rule of personal responsibility
ethnic	slander
false imprisonment	values
informed consent	

How does a profession differ from a job? Many different definitions have been advanced for *profession*. Generally speaking, a profession is more than a field of study; it is the application of specialized knowledge in a way that benefits others and carries a high degree of responsibility to the community it serves. A profession is organized to govern itself: to effectively set standards of professional behavior, education, and qualification to practice and to enforce those standards within its ranks. Having a peer-reviewed journal or publication is also expected of a profession. This allows the profession to advance and to continually review and challenge the knowledge on which it is based.

Limited operators are taking the first steps toward making limited radiography a profession, and they have not yet attained true professional status. On the other hand, their work is closely associated with that of physicians, nurses, and other health care professionals. The public does not usually distinguish between limited x-ray machine operators (LXMOs) and professional radiologic technologists. Any person who cares for the sick or injured and who uses equipment that produces ionizing radiation has a duty to perform competently and professionally. For these reasons, a high level of professionalism in both attitude and behavior is expected of the limited operator. Strict adherence to professional standards by limited operators will hasten the day when professional status is achieved. As a limited operator, your work must be focused on the patients in your care, and your efforts must be devoted to providing high-quality service. It is a primary goal of this text to assist you in this effort.

ETHICS, MORALS, AND VALUES

Correct behavior or “right action” may be dictated by moral, legal, or ethical considerations. **Morals** are right actions based on religious teachings. Most religions have similar guidelines for the proper conduct of life and relationships. Such concepts as honesty, fairness, and compassion are cultural standards based on moral principles. When principles are in conflict—for instance, in a situation in which it may not seem compassionate to be honest—**values** will determine which concept prevails. Values comprise the priority that is placed on the significance of various moral concepts. Values differ among individuals; morals, although they are matters of individual choice, are largely dictated by the culture.

Laws, on the other hand, are legal requirements for behavior. In this way, the government can control the behavior of groups and individuals. Laws govern health care delivery, the practice of radiography, and certain interpersonal interactions. Legal matters that are important to limited operators are discussed in the later section on legal considerations.

Ethics are rules that apply values and moral standards to our actions. Professional ethics define what is meant by correct behavior within a profession. A code of ethics is a

document that sets forth these professional standards. A code of ethics is a hallmark of a profession because it signifies high principles of professional behavior and willingness by the profession to control its own conduct. Limited operators have yet to develop a code of ethics that applies specifically to this group. This does not mean, however, that there are no applicable standards. State laws and licensing boards may limit the scope of practice and prohibit “unprofessional conduct.”

Standards of Ethics for Radiography

As the employee of a physician or health care organization, the limited operator must strive to support and uphold the ethics that apply to all health care personnel. In general, the ethics of health care require that *all* patients receive respectful, competent, and compassionate care. The dignity and confidentiality of each patient must be respected by those who provide health care.

The *Standards of Ethics* for the profession of radiologic technology is a two-part document that consists of a Code of Ethics and Rules of Ethics. Both are developed and adopted by the American Registry of Radiologic Technologists (ARRT) (see Chapter 1). They are published by the ARRT and are available on the ARRT website at www.ARRT.org. The Code of Ethics is an aspirational document that establishes a high standard of professional conduct and assists the members of the profession in practicing ethical principles. It is reproduced in Box 20.1. The Rules of Ethics are mandatory standards of minimally acceptable professional conduct for all registered radiologic technologists and applicants for certification by the ARRT.

Although both the Code and the Rules apply directly to those who are certified by the ARRT, they are very important to limited operators as well. Until such time as limited operators have established themselves professionally and have their own code of ethics, *this is the standard by which all who practice radiography will be judged.*

American Registry of Radiologic Technologists Code of Ethics

The 11 principles of the ARRT Code of Ethics are self-explanatory. Some of these concepts are expanded in other sections of this chapter. Principles 3, 5, 7, and 9, however, deserve additional attention here.

Principle 3 requires radiographers to put aside all personal prejudice and emotional bias when rendering professional services. This is more difficult than it may at first appear. Most of us can easily identify prejudice in others, but our own biases or judgments may be beyond our awareness or may seem to be fully justified or “only common sense.” All of us have some natural preferences that may result in discriminatory treatment if we are not fully aware of them. With what patients do you feel most

Box 20.1

American Registry of Radiologic Technologists Code of Ethics

The Code of Ethics forms the first part of the *Standards of Ethics*. The Code of Ethics shall serve as a guide by which Certificate Holders and Candidates may evaluate their professional conduct as it relates to patients, health care consumers, employers, colleagues, and other members of the health care team. The Code of Ethics is intended to assist Certificate Holders and Candidates in maintaining a high level of ethical conduct and in providing for the protection, safety, and comfort of patients. The Code of Ethics is aspirational.

1. The radiologic technologist acts in a professional manner, responds to patient needs, and supports colleagues and associates in providing quality patient care.
2. The radiologic technologist acts to advance the principal objective of the profession to provide services to humanity with full respect for the dignity of mankind.
3. The radiologic technologist delivers patient care and service unrestricted by the concerns of personal attributes or the nature of the disease or illness, and without discrimination on the basis of race, color, creed, religion, national origin, sex, marital status, status with regard to public assistance, familial status, disability, veteran status, age, or any other legally protected basis.
4. The radiologic technologist practices technology founded upon theoretical knowledge and concepts, uses equipment and accessories consistent with the purposes for which they were designed, and employs procedures and techniques appropriately.
5. The radiologic technologist assesses situations; exercises care, discretion, and judgment; assumes responsibility for professional decisions; and acts in the best interest of the patient.
6. The radiologic technologist acts as an agent through observation and communication to obtain pertinent information for the physician to aid in the diagnosis and treatment of the patient and recognizes that interpretation and diagnosis are outside the scope of practice for the profession.
7. The radiologic technologist uses equipment and accessories, employs techniques and procedures, performs services in accordance with an accepted standard of practice, and demonstrates expertise in minimizing radiation exposure to the patient, self, and other members of the health care team.
8. The radiologic technologist practices ethical conduct appropriate to the profession and protects the patient's right to quality radiologic technology care.
9. The radiologic technologist respects confidences entrusted in the course of professional practice, respects the patient's right to privacy, and reveals confidential information only as required by law or to protect the welfare of the individual or the community.
10. The radiologic technologist continually strives to improve knowledge and skills by participating in continuing education and professional activities, sharing knowledge with colleagues, and investigating new aspects of professional practice.
11. The radiologic technologist refrains from the use of illegal drugs and/or any legally controlled substances which result in impairment of professional judgment and/or ability to practice radiologic technology with reasonable skill and safety to patients.

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comfortable? Men? Women? Those of your own race? Those over 16? Under 65? Middle class? Do you feel greater compassion for a patient with a heart problem than for one with a sexually transmitted disease? Once we identify those areas in human relationships where we are most at ease, it becomes apparent that we are less comfortable in some situations or would prefer to avoid these situations altogether. It is instructive to pay attention to how we deal with patients who are outside our “comfort zone.” Sometimes we tend to act more friendly or solicitous to cover up our feelings. At other times we may remain aloof, appearing to be preoccupied because we are in a hurry. Lack of interest and concern is unacceptable, and feigned concern or pretended interest is never the same as the real thing. Faithfulness to the spirit of principle 3 requires a high degree of self-awareness and presents a serious professional challenge.

Principle 5 deals with the question of professional responsibility. It implies that radiographers are sufficiently educated and experienced to be capable of independent discretion and judgment. Within the scope of their professional activity, they are expected to be both capable of making decisions and accountable for the

decisions they make. A very important aspect of assuming this responsibility is awareness and acceptance of your limitations. Although responsibilities may vary with the working environment, regular duties should be specified in job descriptions and must be consistent with the permitted scope of practice. It is in no one's interest to perform tasks without adequate knowledge or to undertake a responsibility without proper qualification. This principle also holds individuals accountable for errors committed under the orders of another person, if the responsible person knew, or *should have known*, that the order was in error.

Principle 7 requires that radiographers adhere to accepted practices and make every effort to protect themselves and all patients and staff from exposure to unnecessary radiation. The ethical implications of this issue are very important. When this principle is violated, there is no telltale evidence. The negative consequences of other breaches of ethics might be immediate, but the latent effects of unnecessary radiation exposure may not be apparent for 10 to 20 years, and genetic effects may not manifest themselves for several generations. Making every effort to minimize radiation exposure—even when the

patient is difficult to handle, even when you are really in a hurry, and even when no one is watching—requires both good habits and a strong ethical commitment to radiation protection.

Principle 9 relates to the confidentiality of information in a health care setting, which is one of the cardinal concepts in all codes of ethics relating to health care. The confidentiality of conversations between patients and their physicians is considered so important that, along with communications to lawyers and the clergy, it is protected by “legal privilege.” This means that the professional cannot be required to divulge such information, even when doing so might be of material value in a court of law. Limited operators and radiographers often hear conversations between patients and their physicians, and they have access to information contained in patient records. Patients may confide in them, and they may be present in circumstances in which patients are unable to preserve their dignity and may behave in ways that would cause them shame or embarrassment if known to friends or family. All of this information is considered confidential. Many patients do not want it known that they are ill. Some may wish to keep the diagnosis confidential. Information that seems of no consequence to you may constitute a very sensitive issue for the patient. Any breach of confidence, even if no names are mentioned, may rightly be interpreted by others as an indication that the limited operator does not respect professional confidence. Betrayals of confidence cause individuals to lose faith in health care providers and may prevent them from revealing facts essential to their care.

The patient’s right to confidentiality is not violated by appropriate communications among health care workers when the information is pertinent to the patient’s care. It is justifiably assumed in such a case that the transfer of information is for the patient’s benefit and that all personnel involved are bound by the ethics regarding confidentiality. Appropriate communications are those directed privately to those who have a need for the information. Conversations about patients must never be held in public areas such as waiting rooms, elevators, or cafeterias.

The ethics of patient-staff communication also require the exercise of sound judgment and restraint to avoid exposing patients to the health care worker’s personal concerns or the problems of the staff. Using the patient as a sounding board for complaints or gossip is inexcusable.

Ethical Judgments and Conflicts

The process of ethical analysis is a method of evaluating situations in which the correct action is in question. Although some situations may be obviously unethical and unacceptable to almost everyone, circumstances often occur that present conflicts between values, and the best solution is not immediately apparent. In the face of an ethical dilemma, you must be prepared to assess the problem objectively and come to a conclusion that you can

implement and defend. Ethical analysis is a process involving the following four basic steps:

1. Identify the problem
2. Develop alternate solutions
3. Select the best solution
4. Defend your selection

You may realize that there is a problem before you have fully identified it. Identifying the problem means that you can state the conflict clearly. It may be helpful to write it down. It is important to consider every aspect of the problem, to be certain that you have all the pertinent information, and to be confident that your information is accurate. Do not rush this process. A competent identification of the dilemma is essential to its successful resolution.

Once the problem is well defined, the next step is to proceed with the development of alternative solutions. In this part of the process, think of as many potential solutions as possible. This is a brainstorming exercise in which no judgments are made. View the problem from the perspective of everyone involved. Include not only the interests of individuals, but also those of your institution, your profession, and society as a whole.

Only after you have an exhaustive list of possible resolutions does the next step in the process begin: the selection of the *best* alternative. This is the most stimulating and challenging part of the analysis, in which you weigh the alternatives and render a judgment as to which is best. In this process, you will need to eliminate choices that have positive attributes and possibly one or two that you particularly like.

When the best alternative has been selected, you should be prepared to explain your choice based on the standards that affected your decision. By what standard, then, should the alternatives be judged and defended?

Both moral principles and ethical theories provide guidelines for determining whether actions are right or wrong. No one system serves adequately for all occasions. Although religious literature and educational systems may have instilled moral rules, there is no comprehensive list of moral principles that is universally accepted and available as a resource. Ethical theorists have tried to codify moral rules into sets of generally accepted principles, but they are not all in agreement.

Principle-based ethics, also called *principlism*, is a widely accepted standard for selecting and defending solutions to ethical dilemmas in health care communities. Six moral principles, sometimes called *ethical principles*, are accepted as guides to right action that should be respected unless there is a compelling moral reason not to do so. The six principles are the following:

1. *Beneficence*: goodness. Actions that bring about good are considered right.
2. *Nonmaleficence*: no evil. An obligation not to inflict harm.
3. *Veracity*: truth. An obligation to tell the truth.
4. *Fidelity*: faithfulness. An obligation to be loyal or faithful.

5. **Justice:** fairness. An obligation to act with equity.
6. **Autonomy:** self-determination. Respecting the independence of others and acting with self-reliance.

Now let us consider the dilemma of Jackie Webber and evaluate her problem using ethical analysis.

For over a year, Jackie Webber has worked for Dr. Savage in his clinic. Recently Jackie has noticed that Dr. Savage has been returning to the office later and later after the lunch hour. Several times she was certain that he smelled of alcohol, and he often seemed distracted and unfocused after lunch. This afternoon, as Dr. Savage was performing a minor sterile procedure, he dropped an instrument on the floor and bent over to pick it up. Jackie stepped forward, picked up the instrument, and brought another sterile instrument from the supply cabinet, but she sensed that if she had not intervened, Dr. Savage would have picked up the instrument and continued with the procedure.

1. **Identify the problem:** Jackie suspects that her employer may be treating patients and performing invasive procedures while under the influence of alcohol.
2. **Develop alternate solutions:** Jackie considers the dilemma and lists the following possible actions:
 - Do nothing at all.
 - Ask around the clinic and see if any of her coworkers have noticed that Dr. Savage seemed drunk.
 - Tell Dr. Savage that she suspects he is treating patients under the influence of alcohol and see what he says.
 - Warn Dr. Savage that if he does not stop drinking at lunch, she will have to report him.
 - Discuss the issue with the office manager, who is Dr. Savage's wife.
 - Discuss the issue with Dr. Savage's partner, Dr. Melcher.
 - Send an anonymous letter to the Board of Medical Examiners.
 - Send a signed letter to the Board of Medical Examiners.
 - Resign her position and look for another job without mentioning the issue of Dr. Savage's drinking.
3. **Select the best solution:** Is there a solution that will protect Dr. Savage's reputation if Jackie's suspicion is unfounded? How might the rights or the care of Dr. Savage's patients be affected by Jackie's actions? Does Jackie have a duty to judge Dr. Savage's actions? Is there any way to confirm or refute her suspicions without spreading rumors or slandering Dr. Savage?
4. **Defend your selection:** The basic principle of nonmaleficence is often expressed as, "First, do no harm." Because the potential for harm to Dr. Savage's patients may be great, Jackie must act. Principle 5 of the ARRT Code of Ethics states, "The radiologic technologist assesses situations; exercises care, discretion and judgment; assumes responsibility for professional decisions; and acts in the best interest of the patient." This is clearly a case in which Jackie's

discretion, judgment, and responsibility are called for. Which course of action best fits this description? Defend your answer.

Ethical analysis is being used increasingly to solve institutional problems. When several individuals have analyzed the situation, the next step may be to seek resolution through discussion that leads to consensus. Once the question is resolved, action can be taken. The one responsible for implementing the ethical decision is called the *moral agent*.

Ethical conflicts may trouble us when the ethics of the group are not compatible with our personal beliefs. For example, there are health professionals who find that caring for some patients with acquired immunodeficiency syndrome (AIDS) offends their personal sense of morality because they disapprove of the homosexual lifestyle. For others, the conflict between their religious beliefs and the legal right of a patient to receive an abortion may present a problem. Professionals must not permit issues of personal morality to supersede the group moral duty to provide high-quality patient care. Although ethical standards might pose personal moral challenges, these standards assure us that professional ethical judgments will hold true for everyone in similar circumstances. They test whether a specific behavior will support the values and duties of the profession. If you experience frequent ethical conflicts that cannot be resolved, you may need to find a new position or career that conforms more closely to your own moral standards.

Patients' Rights

Considerable emphasis is placed on consumer advocacy in our society, and this value is especially significant in the field of health care. As a result, many organizations and health care institutions have written statements listing patient rights. The American Hospital Association publishes a patient information pamphlet about patient rights entitled *The Patient Care Partnership: Understanding Expectations, Rights and Responsibilities*.^a Although some of these concepts apply specifically to physicians or hospitals, several of them are especially pertinent to the work of radiographers and limited operators.

Considerate and Respectful Care

Foremost among patients' rights is the right to "high-quality hospital care." This statement is self-explanatory and applies to every patient regardless of current status. This is essentially the same professional behavior prescribed by principles 2 and 3 of the ARRT Code of Ethics.

The right to considerate and respectful care implies the expectation that the patient's modesty will be respected and that every effort will be made to assist the patient in maintaining a sense of personal dignity. The limited

^a www.aha.org/advocacy-issues/communicatingpts/pt-care-partnership.shtml.

operator must remember that many health care procedures may threaten the patient's modesty and dignity. Patients are likely to be much more sensitive in these situations than the health care workers, for whom the procedures are an everyday occurrence.

Somewhat related to this right is the generally accepted practice of ensuring that a patient and a physician or other health care worker of the opposite sex are not left alone together in a setting that requires undraping of the patient or examination of the genitals or female breasts. A chaperone, preferably of the same sex as the patient, should be present when possible. The objective of this practice is not to prevent the health professional from violating ethical principles, although this may be a consideration. The main purpose is to ease the patient's mind if he or she fears such an encounter and to provide a witness in case the patient later claims to have been assaulted or touched in an unprofessional manner. Many health care organizations have policies that apply in these situations, and many physicians prefer to be chaperoned, even when no such policy exists. The limited operator should be aware of any such policies and be sensitive to others' needs in this regard. Similar considerations may affect decisions about whether to allow parents to observe the care provided to their minor children.

Note that students and others not required for a procedure must have the patient's permission to be present. The taking of photographs other than for the sole purpose of the patient's care also requires consent.

A Clean and Safe Environment

Health care facilities have a duty to provide an environment that is both clean and safe, and patients have a right to expect that this duty will be carried out. Your responsibilities with respect to cleanliness and safety are discussed in detail in Chapter 21.

Information

The patient also has a right to information, but this does not place an obligation on you to provide any and all information that may be requested. Limited operators must be prepared to offer explanations of radiographic procedures and to identify themselves and the physicians with whom they work. Patients have a right to know whether those involved in their care are students or trainees. They also have a right to be involved in their care and to receive answers to questions about their diagnosis, treatment, and other aspects of care; responding to these questions is the duty of the physician. Your duty in this regard is simply to refer the patient to his or her doctor.

Confidentiality

The right of confidentiality is discussed earlier in this chapter. The Health Insurance Portability and Accountability Act (HIPAA) was enacted in 1996 and has two main provisions. Title I provides for continuing health care coverage for workers and their families when there is a loss or change of employment. Title II, which concerns us here, requires

the US Department of Health and Human Services (HHS) to protect the privacy rights of patients and increase the efficiency of the health care system by drafting rules and creating standards for the use and dissemination of health care information. These rules are intended to provide for the protection of patient privacy as health care information is maintained electronically and transmitted from one agency to another. Since April 2003, hospitals have been required to provide protection for patients concerning the release of individual financial and medical information without the written consent of the patient. No information may be released to employers, financial institutions, or other medical facilities without specific permission from the patient. In brief, this law requires the following:

1. The patient must receive a clear written explanation of how the health provider may use the disclosed information.
2. The patient will be able to see and copy records and request amendments.
3. A history of routine disclosures must be available to the patient.
4. Health care providers must obtain consent before sharing routine information about treatment, payment, and health care operations. Separate authorization is needed for nonroutine disclosures and nonhealth purposes.
5. Patients have the right to request restrictions on uses and disclosures of their information.
6. Patients may file complaints with a covered provider or with the HHS about violations of these rules.

Your health care facility will have specific written procedures to ensure compliance with HIPAA standards. It is your duty to be familiar with these procedures and to apply them conscientiously. The following practices are examples of specific applications of HIPAA standards as used in some institutions:

- No schedules or other documents that include patients' names may be posted in public areas.
- Use only patients' first names when summoning them from public areas. Avoiding the use of last names is preferred to preserve a degree of anonymity.
- All health record information used for statistical or research purposes must be deidentified by eliminating any names, numbers, codes, or biometric identifiers associated with a specific person.
- When the release of medical information is authorized, only the specific information designated in the authorization may be included in the release. A copy of the authorization must be kept on file.
- Only specific individuals trained in HIPAA compliance are allowed access to protected health care information.
- All computer files that contain or may contain patient information must be encrypted. Secure access is required for these data.

Refusal of Treatment or Examination

All patients have the right to refuse treatment, which also implies the right to refuse examination. If a patient

chooses to exercise this right, you must not proceed with the study. Signing an informed consent document does not invalidate the patient's right to refuse treatment once the procedure has begun. Consent may be revoked at any time during the procedure. If this occurs, take time to explore the reason for the patient's unwillingness to continue. This may be a response to a temporary discomfort and not an objection to the procedure itself. Experience with these situations will allow you to respond with tact and concern, calming the patient so that the examination can be resumed. If the patient still refuses to complete the procedure, comply gracefully and notify the physician. When patients wish to leave a clinic or outpatient facility, they must not be prevented from doing so.

Informed Consent

Although patient consent to routine procedures is implied by the continued acceptance of care, **informed consent** is necessary for any procedure that is considered experimental or that involves substantial risk. Certain imaging procedures require that the patient receive an explanation of both the procedure and the potential risk, and the patient must sign a consent form. This is particularly true for procedures involving the use of contrast media. When informed consent is required for complex procedures or surgery, the physician will provide the information and obtain the consent. For patients undergoing more routine procedures, a staff member may provide the necessary form and explanation (Fig. 20.1).

Most procedures commonly performed by limited operators do not require informed consent. When it is your duty to obtain informed consent, be sure that you are prepared with a full understanding of the procedure and its risks so that you can give an adequate explanation to the patient and answer any questions. If the patient asks a question for which you are not prepared, seek the correct

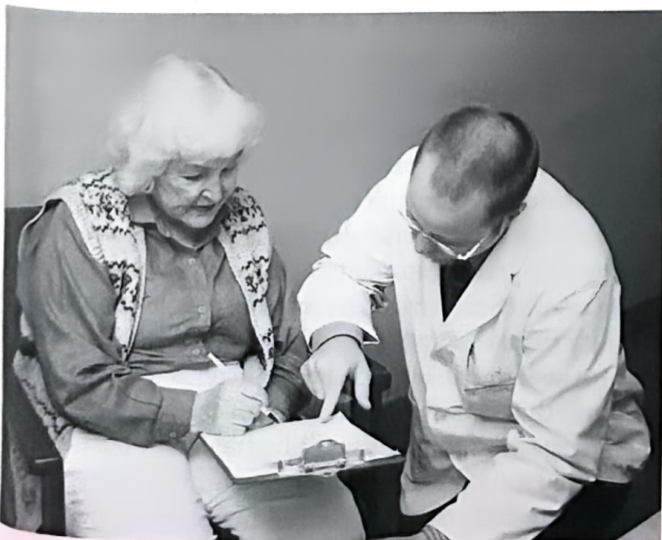


Fig. 20.1 Limited operator obtaining informed consent.

answer before continuing. An improper response can invalidate the consent. The legal implications of informed consent cannot be overemphasized. Successful lawsuits against health care providers have been based on lack of compliance with the following guidelines:

- Patients must receive a full explanation of the procedure and its risks and sign the consent form before being sedated or anesthetized.
- A patient must be legally competent to sign an informed consent.
- Only parents or legal guardians may sign for a minor.
- Only a legal guardian may sign for a mentally incompetent patient.
- Consent forms must be completed before being signed. Patients should never be asked to sign a blank form or a form with blank spaces "to be filled in later."
- Only the physician named on the consent form may perform the procedure. Consent is not transferable from one physician to another, even an associate.
- Any condition stated on the form must be met. For example, if the form states that a family member will be present during the procedure, the consent is not valid if the family member is not in attendance.
- Informed consent may be revoked by the patient at any time after signing.

It is your responsibility to be aware of which procedures require written consent and to be certain that these forms are in order before proceeding with the examination.

LEGAL CONSIDERATIONS

Violations of Local and Institutional Standards

It is essential to maintain all required credentials. In states that require a current license or permit to practice radiography, practicing outside the legal requirements may result in fines, loss of credentials, or even imprisonment. Failure to maintain the qualifications required by your employer may result in termination of your employment. Infractions of laws or professional rules may make it impossible for you to obtain professional standing and/or employment as a limited operator in the future.

Intentional Misconduct

Personal injury lawsuits are becoming more and more common in the field of health care, and all fall into one of two categories: **intentional misconduct** or **negligence**. The types of intentional misconduct that may occur in a health care setting include assault, battery, false imprisonment, invasion of privacy, and libel or slander (defamation of character).

Assault may be defined as the *threat* of touching in an injurious way. The person need not be touched in any way

for assault to occur. If the patient feels threatened and has cause to believe that he or she will be touched in a harmful manner, justification may exist for a charge of assault. To avoid this, the limited operator must explain what is to occur and reassure the patient in any situation in which the threat of harm may be an issue. *Never use threats to gain a patient's cooperation.* This statement applies to both pediatric patients and adults.

Battery consists of an unlawful touching of a person without consent. This should not prevent the radiographer from placing a reassuring hand on the patient's shoulder when there is no intent to harm or to invade the patient's privacy. Nevertheless, if the patient refuses to be touched, that wish must be respected. Even the most well-intentioned touch may constitute battery if the patient has expressly forbidden it. A radiograph taken against the patient's will or on the wrong patient could also be construed as battery. This emphasizes the need for consistently double-checking patient identification and for being certain that proper informed consent has been obtained for procedures that require it. The accepted standard for checking identification is to ask the patient to state his or her full name and birth date and to check these identifiers against the order and any written documents that pertain to the procedure.

False imprisonment is the unjustifiable detention of a person against his or her will. This becomes an issue when the patient wishes to leave and is not allowed to do so. Inappropriate use of physical restraints may also constitute false imprisonment. Reasonable judgment must be used to decide whether restraints are necessary for safety. *Physical restraints that tie down an adult patient's hands or legs are applied only on the order of a physician.* It is rare for restraints to be used in outpatient facilities.

Invasion of privacy charges may result when confidentiality of information has not been maintained or when the patient's body has been improperly exposed or touched. Respect for the patient's modesty is vitally important. The significance of confidentiality is reemphasized here. Health care facilities, physicians, and their employees may be liable if they disclose confidential information obtained from a patient or contained in the medical record. If the information disclosed reflects negatively on the patient's reputation, there may also be justification for a claim of **defamation of character**. Liability for invasion of privacy can result if photographs are published without a patient's permission.

Libel and **slander** refer to the malicious spreading of information that results in defamation of character or loss of reputation. *Libel* usually refers to written information; *slander* is more often applied to information spread verbally. It should be clear that any breach of confidentiality is not only unethical but could also cause the limited operator to be sued for slander and/or invasion of privacy.

Intentional misconduct as discussed in this section often causes emotional distress in addition to any harm caused

directly by the misconduct. For this reason, charges of intentionally inflicting emotional distress may be added to any of these other charges. Occasionally such a charge may be made on its own merit without being accompanied by other charges of misconduct.

Negligence and Malpractice

Negligence refers to the neglect or omission of reasonable care or caution. The standard of reasonable care is based on the doctrine of the **reasonably prudent person**. This standard requires that a person perform as any reasonable person would perform under similar circumstances. In the relationship between a professional person and a patient or client, the professional has a duty to provide reasonable care. An act of negligence in the context of such a relationship is defined as professional negligence or **malpractice**. The LXMO is held to the standard of care and skill of the "reasonably prudent limited operator."

There has long been a tendency to place legal responsibility on the highest authority possible. For instance, according to the legal doctrine of **respondeat superior** ("let the master respond"), the employer is liable for employees' negligent acts that occur in the course of their work. In recent years, however, the **rule of personal responsibility** has been increasingly applied. This means that each person is liable for his or her own negligent conduct. Under this rule, the law does not allow the wrongdoer to escape responsibility even though someone else may be legally liable as well.

Malpractice lawsuits against physicians, hospitals, and health care workers are becoming increasingly common. As a result, rates for malpractice insurance coverage have soared; this topic is a serious concern to all health care professionals.

There has been much discussion about whether radiographers and limited operators should carry malpractice insurance. Health care facilities carry liability insurance, which covers them in the case of negligence by employees acting in the course of their employment. This coverage may also apply to employees individually. Limited operators should learn the extent and provisions of malpractice coverage provided by their employers.

Malpractice lawsuits have resulted in unfavorable judgments against radiographers as individuals. In rare cases, insurers who have paid malpractice claims have successfully recovered damages from negligent employees by filing separate suits against them. Some believe these are sufficient reasons to be protected by their own liability insurance policies. Others argue that the potential for a large insurance settlement is an incentive to sue, and that if the limited operator has no means of paying a large claim, no suit will be filed. The possibility of losing personal assets, such as one's home, may provide motivation for considering the purchase of malpractice insurance.



Box 20.2

The Seven C's of Malpractice Prevention

Competence: knowing and adhering to professional standards and maintaining professional competence reduce liability exposure.

Compliance: the compliance by health professionals with policies and procedures in the medical office and hospital avoids patient injuries and litigation.

Charting: charting completely, consistently, and objectively can be the best defense against a malpractice claim.

Communication: patient injuries and resulting malpractice cases can be avoided by improving communications with patients and among health care professionals.

Confidentiality: protecting the confidentiality of medical information is a legal and ethical responsibility of health professionals.

Courtesy: a courteous attitude and demeanor can improve patient rapport and lessen the likelihood of lawsuits.

Carefulness: personal injuries can occur unexpectedly on the premises and may lead to lawsuits.

Reprinted with the permission of David Karp, loss prevention manager for the Medical Insurance Exchange of California.

Lawsuits can result in conflict, expense, professional embarrassment, and loss of public confidence even when the patient is denied any award. For these reasons it is very important to use caution, both in the interest of quality patient care and in the avoidance of possible malpractice claims. Research indicates that lawsuits are most likely to occur when patients feel alienated from the people providing their care. When a trusting professional relationship is established, suits are less likely. The Seven C's of malpractice prevention (Box 20.2) is a list of considerations to reduce the likelihood of lawsuits and legal liability for negligence in the health care setting.

Proper patient identification, accuracy in medication administration (see Chapter 23), and compliance with patient safety requirements (see Chapter 21) are positive steps the limited operator can take to prevent malpractice suits. Harm may result when medications or contrast media are administered without proper precautions or when drug reactions are not immediately identified and appropriately treated. Poor image quality creates a potential for misdiagnosis that may have serious consequences for both patient and limited operator. The potential for harmful error is often greatest in stressful situations. Appropriate responses in an emergency ensure the least possible risk. You must understand and accept that an appropriate response depends on your level of experience and education. Do not hesitate to ask questions and receive help when needed.

The limited operator can also protect patients and the employer by reporting illegal or unethical professional

activities to the proper authority. In such a situation you must take care to be neither too zealous nor too hesitant. A simple written statement that includes the facts (dates, times, names, and places) but avoids judgments or conclusions should be prepared as soon as possible after the occurrence. This statement should be submitted to the appropriate person, probably your immediate supervisor, unless he or she was involved in the incident. The supervisor receiving such a report is responsible for seeing that it is given to the proper authority, who must then follow up by investigating. A single report may not produce change, but it may add strength to other reports or lead to increased supervision where necessary.

PROJECTING A PROFESSIONAL ATTITUDE

Think for a moment of a physician, nurse, or other health care worker that you have encountered when you were a patient. If this person had a neat, appropriate appearance, spoke in a way that was friendly and concerned but not too familiar, and projected an air of confidence and competence, you probably perceived that this person demonstrated a professional attitude. Patients expect professionalism in health care workers and will be most likely to respond with cooperation and confidence when these expectations are met. A professional attitude also promotes positive relationships with coworkers and employers.

Self-Care

A limited operator who is not healthy is not a good health role model and cannot function effectively for both physical and psychologic reasons. Health is a state of physical, mental, and social well-being. To help others, we must first meet our own physical and mental needs. Certain needs are common to everyone and can be listed and ranked in importance (Fig. 20.2). Any unmet need causes stress and prevents one from experiencing a state of well-being.

Needs on the most basic level are foremost until these needs have been adequately satisfied. As satisfaction

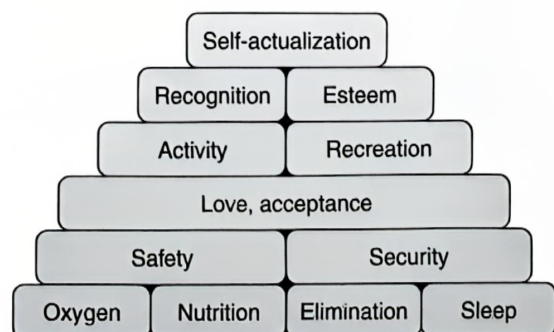


Fig. 20.2 Hierarchy of needs.

occurs on one level, the needs of the next higher level occupy our attention. Self-actualization is the state in which we can express ourselves with a high degree of creativity. Constructively meeting your own needs for well-being, knowledge, and self-esteem enables you to function more fully, free from personal concerns when the patient requires full attention.

Because many patients have a lowered resistance that makes them especially vulnerable to infection, you should not work when you are ill. However, because you are counted on to be present when scheduled, it is even better to prevent the onset of illness. Everyone experiences grief and acute anxiety occasionally, and such stresses can make you susceptible to illness. Whenever possible, you should stay at home to deal with such problems until a resolution is reached. Severe anxiety and stress can prevent you from fulfilling your responsibilities properly.

Do not overlook the importance of good nutrition and exercise habits. These practices pay off in an increased sense of well-being and in less time lost from work. Knowledge and practice of the principles of body mechanics (see Chapter 21) will help prevent the types of injuries that can result from lifting and moving patients or equipment.

Preventive health measures are equally important. For example, health care facilities are required to offer hepatitis B vaccine without charge to employees who are at risk of exposure to this disease. If your work places you at risk of infection from needle sticks or other exposure to potentially contaminated blood, you are responsible for taking advantage of this important protection. The infection control precautions discussed in Chapter 21 have been developed to help prevent transmission of diseases from patient to patient and from patient to you. Your health and that of your patients depend on your commitment to understanding and applying these principles. Minimizing the spread of disease in a health care setting is a primary responsibility of all health care personnel.

If proper precautions are not observed, radiation exposure over the course of a career can have serious health consequences. Chapter 11 provides instruction in radiation protection. Adhering to radiation safety practices is another important aspect of self-care for limited operators.

Job Satisfaction

Most health care workers enter the field with a desire to help and to provide excellent patient care. Sometimes, however, the demands of clinical practice may tend to overshadow your best intentions. Patient needs may be overlooked in the stress of coping with technical demands unless you make a conscious effort to learn, from the beginning, to handle both at once.

Your work will be most satisfying when your contributions and the personal contacts they involve are genuine and sincere. When you do things because you *want* to do them and you enjoy doing them, you will do them well and your work will be much less stressful (Fig. 20.3).



Fig. 20.3 With a high level of job satisfaction, a limited operator begins the day with a positive outlook.

Appearance

Appearance can communicate how we feel about ourselves and our work. Everyone we meet forms an instant impression of who we are. What does your appearance tell patients about you? Similar to many health care workers, limited operators wear uniforms to present a simple, neat appearance. The uniforms are washable and plain to make them easy to keep clean. They should fit comfortably and be worn with simple, appropriate accessories. Avoid jewelry on hands or arms that could injure patients. Although fads and fashions change over time, a professional image will continue to be conservative.

Personal cleanliness and grooming are essential. Keep your fingernails reasonably short and smooth. Wear shoes that are comfortable and quiet to walk in and keep them clean. Use fragrances sparingly. Some patients have an allergic response to perfumes; others find heavy fragrances offensive. Strong fragrances can cause nausea in patients who are ill.

The appearances of the x-ray room and the public areas of your work environment are also important. An untidy, cluttered room does not show respect for patients. It suggests that personnel may be too pressured, too disorganized, or too uncaring to perform competently.

Teamwork

Teamwork is defined as the cooperative effort by the members of a group to achieve a common goal. The pressures of work may sometimes make this concept hard to apply. Your goal should be to provide the best possible patient care, and it is easier to do this when you work cooperatively with others.

Teamwork is a two-way street. If you appreciate help when schedules are tight, you must be sensitive to the needs of your coworkers as well. The essence of teamwork involves

good communication among coworkers. Communication that promotes teamwork is discussed later in this chapter.

Empathetic Care

As stated earlier in this chapter, patients are entitled to considerate and respectful care. This statement applies to every patient, regardless of current status. Dealing effectively with clinical situations involves several abilities. One is the ability to show **empathy**, a sensitivity to the needs of others that allows you to meet those needs constructively, rather than merely sympathizing or reacting to their distress. Understanding and compassion are accompanied by an objective detachment that enables you to provide an appropriate response. For example, you could express sympathy for the victim of a tragic accident by crying or by smothering him with expressions of pity. A more productive expression of empathy would be to show concern and care while quickly and accurately providing the images that could aid in rapid diagnosis and treatment.

Beginners in the care of patients often express concerns such as, “What shall I do if the patient vomits? I just know I’ll get sick, too!” or “I faint at the sight of blood.” As you gain experience and confidence, you will learn to cope by focusing on the patient rather than on yourself. Thoughts of how you can meet the patient’s needs will enable you to project a calm, reassuring attitude.

A focus on patient needs will also help you to respond calmly and assertively when the actions of a patient are inappropriate. It may seem strange or frightening that some individuals respond to stress and anxiety by becoming hostile or even threatening. These are often people who cope with stress by controlling the situation. Preserving a calm, objective attitude is most effective in dealing with these patients.

Overt expressions of sexuality by patients are encountered very infrequently. These events are usually a reflection of anxiety by patients who no longer feel functional as sexual human beings because of their current physical state. With this in mind, you can be less judgmental while setting limits on patient behaviors. In other words, you can refuse to accept the behavior while continuing to reassure and care for the patient.

Care of Supplies and Equipment

Health care facilities must stock large quantities of supplies to function effectively. In such an environment, it is easy to assume that free access implies free use. In truth, however, someone must pay the bill. The value of each inventory item includes an overhead factor that may be two or three times the item’s basic cost. For example, when a sterile item is accidentally contaminated, the loss includes not only the cost of the item but also the costs involved in ordering, accounting, shipping, and storage. Medical supplies and equipment are expensive, and proper care is required to ensure that their value is preserved so

that they are available for use when needed. The misuse of equipment or supplies or their diversion for personal use wastes funds and increases health care costs. The limited operator who avoids such waste is demonstrating a high standard of professional behavior.

Continuing Education

In radiography, as in any rapidly changing technical field, continuing education is necessary to learn about current trends and to maintain competencies. For this reason, limited operators must place a priority on acquiring new skills and expanding their knowledge. Textbooks often contain information that is valid when the manuscript is completed but outdated by the time the book is published. Standard practice changes rapidly, and today’s knowledge will soon be out of date. Some states require continuing education as a condition of license or permit renewal, but continuing education is an important professional responsibility whether it is required or not.

Many opportunities for continuing education are available to the limited operator. Hospitals, colleges, and professional organizations provide educational opportunities that meet the need to stay abreast of current developments and expand skills. Education may take the form of courses, classes, workshops, seminars, and other group experiences, but there is also a variety of materials available for individual learning and self-study, including web-based instruction and correspondence courses.

When you are required to provide evidence of continuing education, be sure to determine in advance whether the education you plan to receive is approved and accredited for this purpose. Keep an accurate record of your continuing education activities and any documentation of participation that you receive. These documents are valuable even if they are not immediately required. Evidence of continuing education may assist your professional advancement by helping you to qualify for a promotion or a new position.

Failure to maintain competence and required certifications places both the employer and the employee at risk and may result in loss of employment and professional reputation. Knowing the credentials required in a given situation and maintaining current credentials are important professional responsibilities.

PROFESSIONAL COMMUNICATION

Communication is an interchange of ideas and information with others. How we communicate involves our attitudes and our manners. Attitude is a state of mind or an opinion that can be revealed by body position, tone of voice, facial expression, and other nonverbal signals. Manners are customs that express respect; they are sometimes referred to as the oil that makes daily contacts run smoothly.

Accurate communication is essential to quality patient care. The ability to give instructions depends on the speaker's being clear and precise. The listener, on the other hand, is equally responsible for attentive and receptive behavior. The need to establish rapport with both patients and coworkers by listening attentively and responding in a meaningful way can easily be overlooked under the pressures of a busy schedule. Stress in the workplace increases when interpersonal communication breaks down and good manners are neglected.

Nonverbal Communication

Although we perceive verbal language as our primary means of communication, nonverbal behaviors reveal a great deal about how we feel. Cultural background largely determines how nonverbal communication is interpreted. Most of us learn to respond to common cues in childhood. We perceive frowns or pursed lips as disapproval. Refusal to look directly into an individual's face while speaking conveys avoidance, submission, or rejection, whereas clenched teeth or fists suggest angry feelings under rigid control. Patients in pain may present a tight and rigid protective posture. Leaning forward while listening to another gives the appearance of intense interest in the subject being discussed.

As a rule, a positive and caring attitude naturally results in nonverbal behaviors that are also positive. The reverse is also true. A negative attitude will be unconsciously revealed, no matter what is said. What common nonverbal language do you recognize (Fig. 20.4)?

Eye Contact

In the United States, eye contact is considered a positive behavior. When you make direct eye contact with an individual while speaking, it is usually perceived as an expression of interest, concern, or honesty. As you will learn in a later section on culture and communication, it is important to remember that direct eye contact is not welcome in all cultures.

Touching

Touch is a means of communication, too. An abrupt or tentative touch may be perceived as distaste or reluctance to care for the individual. A positive touch is firm but gentle and reassures the patient that you are both capable and caring. People touch one another for a variety of reasons, including the following:

- To provide reassurance, support, encouragement
- To imply domination, anger, frustration
- To form a positive connection, as in a handshake or shoulder pat
- To perform professional services, such as those provided by a doctor, hairdresser, or masseuse

Remember that the brief hug around the shoulder that is so reassuring to many Americans may be an upsetting invasion of personal space and privacy to those whose culture does not include a casual embrace. In some cultures and religions, touch by a stranger or a member of the opposite sex is unacceptable or strongly frowned on.

When you must touch a patient, you are much less likely to unintentionally offend if you tell the patient in advance what you are about to do and then use a firm, appropriate touch. It is important that your touch has a professional purpose that is clear to the patient.

Verbal Communication

Clear, distinct speech habits help to ensure accurate communication. Try to tailor the content of your speech to the comprehension level of the listener. Chapter 18 provides specific suggestions for communication with children and older adults. Use good eye contact and speak face to face. This approach assures others that they have your full attention and concern.

It is an asset to cultivate an ability to be **assertive**. This does not imply that you need to be **aggressive**. Expressions of aggression involve anger or hostility, whereas assertion is the calm, firm expression of feelings

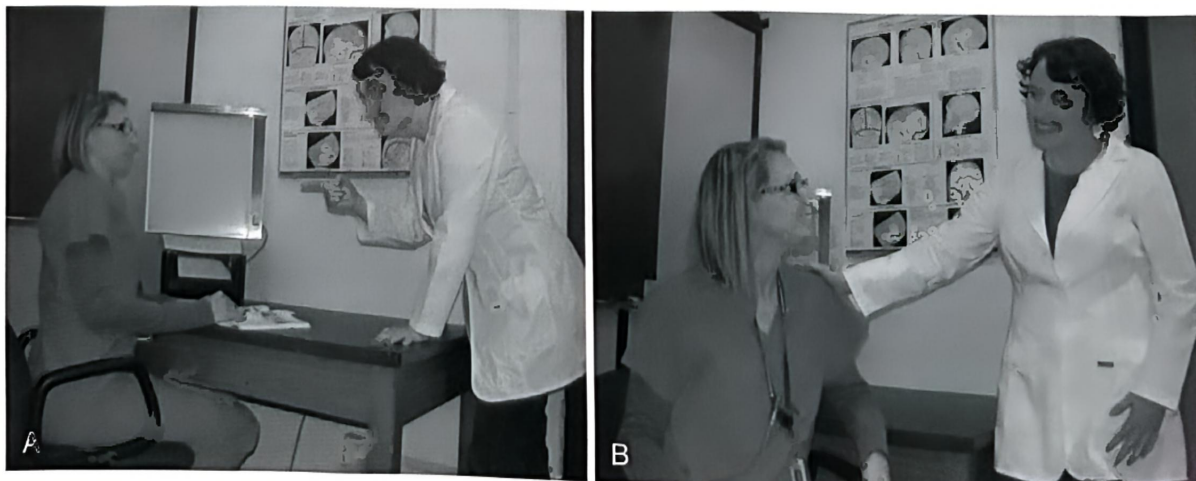


Fig. 20.4 More than 70% of the communication between adults is nonverbal. (A) What message is this supervisor sending? (B) Warmth is not conveyed with words.

or opinions. You have the right to be assertive when you require assistance in a patient care situation that is beyond your ability. Employers may be assertive in requiring employees to maintain the level of competence required by their job descriptions. In dealing with patients who are reluctant to cooperate, pleasant assertiveness is the attitude that is most productive in obtaining compliance.

Listening Skills

How do you feel when you are interrupted or when the listener looks out the window while you attempt to make your point? Are you irritated when others “put words in your mouth” or change the subject without responding to what you have just said? Good communication is a two-way street. A good listener does more than wait his or her turn to speak. Listening skills involve the ability to focus on the speaker and to project an attentive attitude. When you give the speaker full attention, you can respond to what has been said rather than make a quick switch to the next item on your own agenda. In discussion, patients often give us clues about a physical problem that can be easily overlooked if we rush to get on to the next question.

Validation of Communication

Good communication requires validation of understanding. An informal response, such as a smile, nod, or brief “okay,” may be perfectly satisfactory in a social situation, but when essential information is being presented, the response must reflect clear understanding. This is particularly true with all instructions that involve your professional activities. As a listener, you can be sure that you have understood the message by reflecting or repeating the essential elements of the speaker’s statement in your response. When you are imparting information and do not receive a validating response, continue the conversation by asking your listener to restate the information. The conversation that follows is an example of a valid communication between a physician and a limited operator:

Physician: I think Mrs. Kirkland may have a right scaphoid fracture. Please take the routine exam and a Stecher view and let me see them right away.

Limited operator: That’s a routine right wrist plus a Stecher view on Mrs. Kirkland, and I’ll bring them to you as soon as they’re ready.

Physician: Right. Thank you.

The lesson for both speakers and listeners is that messages must be both clear and complete and that comprehension of the message must be confirmed. Without such validation, neither party can be certain that all elements of the message have been understood.

Communication Under Stress

Any situation that disturbs our everyday activities imposes stress. Most health care involves some anxiety and often proves stressful to patients, families, and health care

workers alike. This is especially true in a crisis when speed is a factor or when a complex situation causes disagreement about priorities.

Stress interferes with our ability to process information accurately or appropriately. A classic example is the victim of a house fire who flees with the nearest object, such as a rubber plant, rather than essential papers or treasured family possessions. In a stressful situation, accurate communication can be difficult. The principles of communication already discussed are always important, but these additional suggestions can improve your effectiveness under stress:

- Lower your voice and speak slowly and clearly.
- Be nonjudgmental in both verbal and nonverbal communication.
- Do not allow the inappropriate actions or speech of an upset individual to goad you into a similar response.
- When you are uncertain whether the listener has understood you, request an answer. For example, “Did you read the consent form? What did it ask you about allergies?”

Communication with Patients

The first contact with a patient is usually an introduction. In many social situations today, given names are used as soon as introductions are made. Although this may seem to project an air of friendliness and informality, it also poses certain problems. “Good morning, Mr. Robles. I’m Lisa McCall, the x-ray machine operator,” is more than an example of good manners. It shows respect and concern and allows the patient to choose how he wishes to be addressed. In an effort to show friendliness, some staff may address adults as “honey” or “sweetie” instead of calling them by name. Others, who are focused on the work routine, may refer to “the diabetic in room 2” or “that sprained ankle in the hall.” Talking down to adults or treating them impersonally diminishes their self-esteem and raises feelings of resentment. Such feelings can diminish the ability of the patient to understand and follow directions. These feelings may also prevent retention of information and could actually hinder recovery. Resentment is destructive of the trusting relationship that is essential to high-quality care.

Health care professions are successfully using therapeutic communication to enhance the physical, mental, and emotional well-being of patients. This collection of communication techniques, including active listening, using open-ended questions, focusing, repeating information, clarifying, paraphrasing, and using strategic silence, may improve patient confidence and autonomy, as well as develop trust.

A helpful way to show respect and elevate patients’ self-esteem is to involve them in their own care by giving them opportunities to make choices. Offering a valid choice, as discussed in Chapter 18, requires some thought, but the rewards in terms of patient satisfaction are well worth the effort. The choice does not need to be an earth-shaking decision. Questions such as, “Would you like a blanket

over your knees?” or “Would you like to stop in the restroom before we begin?” can reassure patients who would like to feel capable of making decisions and who need to have a share in their own care. Treating patients as individuals, allowing them to make valid choices, and using good nonverbal skills are tools that alleviate fear and promote cooperation.

In determining why patients fail to follow instructions, one factor frequently encountered is the assumption that the patient understands the procedure. Such an assumption is really just a guess. For example, we could assume that because you are reading this text, you are a student in a radiography or medical assisting program. That could be true, or perhaps you are a nurse and are expanding your professional skills. You might also be an instructor or the proofreader for this book. Making assumptions about patients implies that you might also guess about physical status or mental ability or even about willingness to cooperate. Can you assume that Mr. White, who may have broken his ankle, can be positioned flat on the radiographic table? No. Although his ankle injury might not prevent such positioning, he may have emphysema, which could interfere with his ability to breathe while lying supine.

Conversing with patients allows you to use your powers of observation. Is the patient alert or confused? How well does the patient hear? Is English comprehension a problem? From observation, you can often make a tentative assessment of the patient's ability to get on and off the examination table, walk unassisted to the bathroom, and so forth. Patient assessment is discussed in depth in Chapter 22, but assessment begins with communication. You should learn from this chapter that good communication with patients can help you establish a spirit of trust and cooperation that will assist in both patient assessment and patient care.

Special Circumstances in Communications

Deafness

The deaf patient presents a set of problems unlike those of patients with a hearing loss discussed in Chapter 18. Many totally deaf individuals live in a cultural setting that has its own social structure, language, and even “inside” jokes. Certain cues help in differentiating between the patient with a hearing loss and the deaf patient, especially in an emergency. You may become aware that a seemingly alert patient is totally deaf when he or she does one of the following things:

- Does not respond to noises or words spoken out of the range of vision.
- Uses lip movements without making a sound or speaks in a flat monotone.
- Points to the ears and mouth while shaking the head in a negative motion.
- Uses gestures or writing motions to express the need for paper and pencil.

Some deaf people are adept at lip reading and are able to speak, at least to a limited degree. More often the deaf

are educated in American Sign Language (ASL), which is the most common sign language and is distinctly different from English. It has unique grammar, syntax, and rules. Learning a few basic signs may aid in establishing rapport with deaf patients. A card showing the alphabet and some common signs in ASL should be available through your local hospital's nursing service department or from community service agencies that assist the deaf. An interpreter is essential in any situation that requires complex instruction or an exchange of important information. Deaf patients have the right to choose the most preferred method of communication, which might be pencil and paper. Be sure that writing materials are available and that the patient's writing arm is free.

The health care setting can seem overwhelming, especially when the patient is a deaf child. If possible, allow the child and parents to tour the area before the examination begins. Take time to fully explain the procedure so the parents can help the child understand what to expect. If the child is distressed, you might consider allowing a parent to stay in sight or near the child while following appropriate radiation safety precautions.

Blindness

Most of us depend on our eyes to become familiar with our surroundings and to ensure our safety as we move about. Vision enables us to recognize individuals and locate items of daily living. The ability of a person who is blind to accomplish these same tasks without vision can seem astounding. People who are blind rely on hearing and touch to a much greater extent than sighted persons. With the aid of a cane or guide dog, many people who are blind lead very independent lives. Having learned to work outside the home, use public transportation, and maintain their own households, these patients may be insulted by attitudes that are too solicitous. They may be quite capable of proceeding confidently after a quick description of a room and the obstacles in it. You might say, “This is a square room, Mrs. Lord. The x-ray table is about 5 feet in front of you, and a chair is at 7 o'clock. After you're on the table, I'll be in a booth to your left.” On the other hand, patients who are blind may welcome some special help in a strange environment. Some will prefer to follow you by listening to your footsteps and using a cane, whereas others may wish to place a hand on your shoulder or elbow. Those who are infirm may prefer your arm around their waist while you reassure and direct them verbally. Take care that obstacles such as step stools do not present a safety hazard as blind people move about. None of these approaches applies to all people who are blind. Good communication is the key to determining which form of help is acceptable and appropriate.

Remember that loss of the ability to see, hear, or speak is a communication impairment and not a reflection of the individual's intelligence or ability to think. Patients with sensory deprivation challenge us to be more flexible and innovative in the ways we offer explanations and reassurance.

Impaired Mental Function

Special sensitivity is needed when dealing with adult patients who are mentally or emotionally handicapped. Such patients may include those with congenital defects such as Down syndrome, those with illnesses or injuries affecting the brain, and those with severe emotional disorders that affect comprehension. As with children, you must assess the patient's ability to understand and follow instructions, because this ability may vary from a near infantile response to a functional capability close to normal. In general, the same clear, simple, and direct instructions offered to children are appropriate. You may have to repeat instructions if the patient's attention span is short. Use the adult form of address, and treat these patients with the respect and dignity due anyone their age.

Communication with Patients' Families

When we are sick or injured, the presence of those who care about us is very reassuring and may be essential to our ability to cope. It is natural that family members rush to the emergency room after an accident, visit patients during hospital admissions, and accompany patients to their appointments. You may have to deal with family members who want to hold the patient's hand during a radiographic examination or who eagerly await the results of a diagnostic procedure. When you are busy and the patient is your primary concern, family members may appear as obstacles to your work. Dealing sensitively with families is often necessary and helps your patient in ways that may not be apparent.

Your communication with families often involves the transfer of practical information. Those waiting for a patient want to know how long the procedure will take, and they appreciate an update from you when a delay occurs. When the wait is prolonged, your attention to the waiting family's comfort might include directions to services, such as the restrooms, cafeteria, or telephone.

If the patient is a minor, is incompetent, or is sedated, you may have to provide instructions to a family member regarding preparations or follow-up care. Be sure you are speaking to the person who will actually assist the patient, because information can be lost when it is passed from person to person.

Questions often arise regarding the immediate presence of family members during a procedure. The family must usually stay outside the room, preferably in a waiting area or lobby that is out of hearing range. This is done not only because of radiation safety precautions but also because it allows the staff to proceed without interruptions from concerned family members who may not understand what is happening and may require explanations and reassurance. Procedures that involve patient discomfort or some blood loss may be very unsettling to loved ones. If families are waiting nearby, you should be aware of this and avoid making statements within hearing range that might alarm them or betray a professional confidence.

Occasionally a family member may have to stay with the patient in the procedure room, for example, as with a deaf child, as mentioned earlier. In these situations, only one family member should be selected, and this person should receive a clear explanation before the procedure. You should answer questions at this point and clarify the role of family members. Provide radiation protection as necessary.

Sometimes dealing with families can be especially difficult. In an emotionally charged situation, we all use different means to cope with our anxiety. Some of us become dependent and wait for others to make decisions and give us instructions. Others maintain self-control by withdrawing or denying the importance of the situation. Anxiety causes some individuals to be quite aggressive or controlling when they are communicating about patients who are dear to them. Fear frequently engenders anger. If you can understand aggressive demands for service and attention as being an expression of fear, you can concentrate on reassuring rather than responding with anger yourself. Although you should refer inquiries about diagnosis or prognosis directly to the physician, an expression of concern can demonstrate empathy. "I know how worried you must be about Cynthia, Mr. Roth. I've let the doctor know you're waiting for the results."

Communication with Coworkers

The ability to relay information to other health professionals is essential. The kinds of problems we encounter when we are dealing with patients may also arise when we are communicating with coworkers. The pressures of time and workload may compound the personality conflicts that occur in any group. Good interpersonal relationships are built on the ability to make others feel good about themselves (Fig. 20.5). The nonverbal behaviors that we use with patients, such as touch and appearance, are equally effective with coworkers. Be a good listener. Use

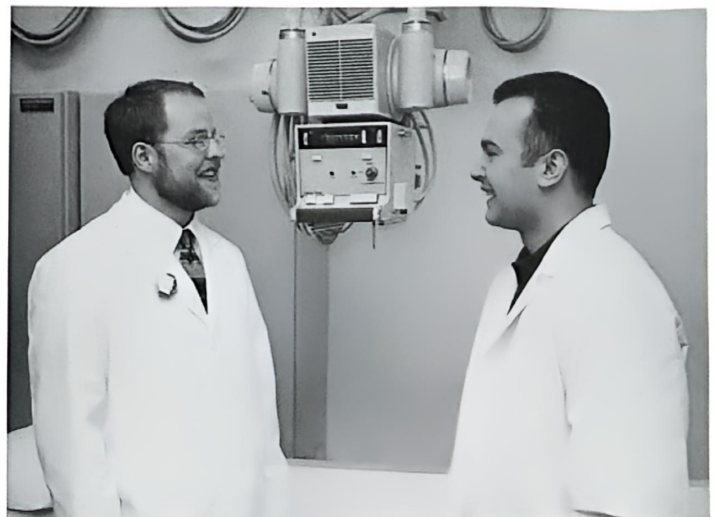


Fig. 20.5 Good interpersonal relationships are built on the ability to make others feel good about themselves.

praise and appreciation as positive reinforcements when work is well done or when others go out of their way to provide assistance. Demonstrate respect for your coworkers as individuals by avoiding cliques and gossip. Especially avoid revealing personal information about your employer and your coworkers to patients or others.

One other concern regarding your interpersonal relationships with coworkers has ethical and legal implications. The pressure of work may make it difficult to find time to exchange general information. For this reason, break or lunchtime is often used to catch up on recent developments and share information. *Never discuss patients in a public setting.* It is acceptable to talk about changes in schedules, the holiday party, or the new computer system, but discussions of interesting cases, celebrity patients, or possible treatment errors can be overheard and used in damaging litigation. Such conversations are invasions of the personal rights and privacy of patients.

In a modern health care facility, a great amount of information is exchanged. Although much of the technical communication is conveyed using charts and forms, it can be equally important to relay informal messages accurately. Attention to details, such as adding your name and the date to telephone message forms and notes for the bulletin board, can help keep information retrieval pertinent.

Most businesses and health care facilities have voice mail systems to facilitate messaging when personnel are away from their telephones. When you receive a voice mail message, it is courteous to call back and confirm that you have received the message. Playing “telephone tag” can be very frustrating to the caller, and the problem is worsened when there is no way to know if the message has been received. When leaving a voice mail message (Fig. 20.6), be sure to identify yourself and your position

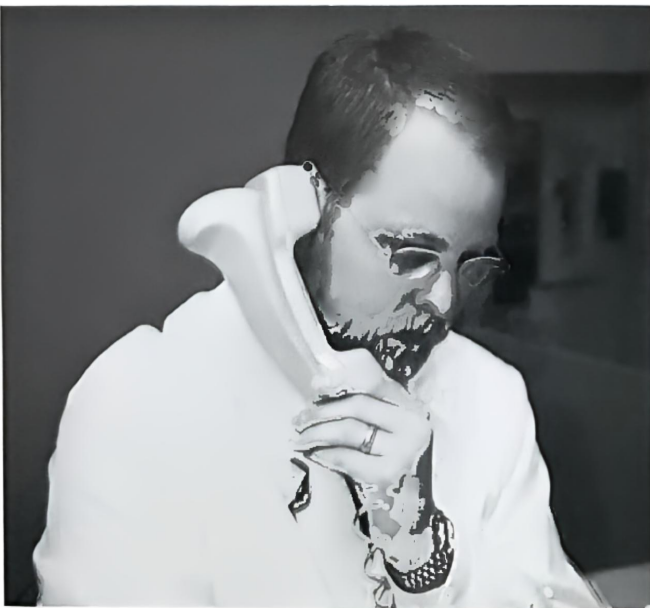


Fig. 20.6 A professional approach to telephone communication improves patient care.

or facility. State the date and time and your telephone number clearly. If you want your call returned so that you can talk to the person, suggest a convenient time to return the call. Here are some additional guidelines for avoiding problems with telephone communications:

- Be familiar with your telephone system, including forwarding and hold functions.
- Identify yourself and your facility or department when calling or answering a call.
- Keep paper handy and make notes during the call to avoid losing details.
- Use a pleasant, receptive tone of voice.
- Validate the message before concluding the call.
- When you are receiving a call for someone else, avoid disclosing personal information. Simply state that the person is unavailable or out of the office and offer to take a message. Be sure that the message is relayed to the proper person or department promptly.

Written communication is valuable only if it is received in good time. Whether this is a telephone message, a personal note, or a change in schedule, try to see that such messages are given directly to the intended individual or posted in plain sight in a predetermined spot. Be sure to identify yourself, your department (if appropriate), and the time the message was sent or received. If a response is needed, remember to include the return address and/or telephone number.

Facsimile transmissions, or faxes, are often used to send information between health care facilities. Physicians may use the convenience of fax transmission to prevent the errors that can occur with verbal telephone orders. If you are responsible for faxing information to another institution, remember to fill out the cover sheet first. Confusion about where the information is needed or who is to receive it can cause needless delays in patient care. When confidential information regarding a patient is to be sent by fax, it should be preceded by a phone call to alert the recipient. Confidentiality is difficult to preserve at best, and such information should be treated in a responsible manner. Most fax machines print out a record of the fax transmission. If it is your duty to transmit information by fax, know the procedure for maintaining this record. It may be attached to the original copy of the document or you may have to note the document's content on the fax record and file it separately.

ISSUES OF CULTURAL DIVERSITY

Non-English-Speaking Patients

Language barriers are not handled very effectively in the United States. Federal legislation addresses the patient's right to understand and communicate effectively in health care situations regardless of language barriers. Most large hospitals now have a service that will arrange for an interpreter when necessary. In a clinic setting, translation is

most often handled by family members. If patients who do not speak English are commonly seen in your facility, you should become familiar with the policies in place for ensuring that communication meets the needs of these patients.

The difference between a certified interpreter and a friend or family member who assumes this role may be significant. The interpreter is trained to translate only what has been said, both by the patient and to the patient, and not to explain what is implied. Family and friends may tend to add inappropriate information or to edit the conversation in an effort to be cooperative or to save time. For example, a complete explanation of positioning and instructions for breathing may be abbreviated in translation to, "It's okay, mama. Just hold still." Family members may hesitate to reveal information about the patient that they believe is private or embarrassing. The patient may hesitate to reveal personal information through family or friends. Family members whose command of English is limited may have good intentions but be unable to provide adequate translation of complex information. The services of a trained interpreter provide a professional bridge in difficult communication situations. As with deaf clients, official interpreters must be used when complex and important information is being exchanged, so that interpersonal relationships will not interfere and the parties to the conversation can be certain that the translations are accurate.

When you are using an interpreter, look directly at the patient and speak as though the patient were able to understand you. The interpreter will translate as you speak or as soon as you have finished a sentence. Speaking to the interpreter directly tends to make the patient feel left out or talked about rather than involved in the process.

If a translator is unavailable, use demonstrations or pencil sketches to validate whether the individual understands and make extensive use of nonverbal encouragement. A friendly smile and a warm touch may be worth many words.

Scope of Diversity

American society today, both urban and rural, is far more culturally diverse than in our great grandparents' day. Data from the US Census Bureau indicate that today the ratio of nonwhites to whites is 1:4 and that by 2070 half of all Americans will be African American, Hispanic, Native American, or Asian/Pacific Islander. Although this diversity poses certain social problems, it also creates a vast richness and creative potential.

Cultural diversity is a global health care issue. Research suggests that there are differences in outcomes of health care treatments that are related to race and ethnicity. Lawmakers have passed legislation to address cultural inequities in health care.^b Your health care facility must plan for transcultural care and will expect staff to develop

the attitudes and the knowledge required to help implement these plans.

The subject of ethnic and cultural diversity is complex and fills numerous textbooks. It is impossible within the scope of this book to anticipate the many diverse ethnic and cultural situations you will encounter in your work. We hope that the limited examples in the discussion that follows will help to raise your awareness of those situations in which sensitivity is needed.

The racial and ethnic (national) characteristics of individuals were originally identified with specific areas of the globe. Africans came from Africa, Chinese from China, and so forth. In many cases, racial characteristics such as skin color, hair texture, and the shapes of facial features were identified with specific cultures as well as with ethnic origins. As opportunities for emigration and travel increased, it became more difficult to identify the national origin of a specific individual. For example, not all patients with Asian features speak an Asian language.

Culture is determined by language and by the customs commonly observed. It can be misleading to generalize about the cultural attitudes and practices of any ethnic group because individual variations within a group depend on so many factors. In addition, the physical appearance of an individual may have no relationship to how extensively he or she has integrated culturally into the mainstream of American life. A person who has recently arrived from Eastern Europe wearing the latest athletic shoes, a baseball cap, and blue jeans may speak little or no English, whereas a patient wearing a turban and a dashiki may have been born in Chicago of ancestors who have lived there for generations.

When cultural diversity is mentioned, customs relating to nationality may be the first things that come to mind. Our society consists of many different groups in addition to ethnic groups, and each has unique characteristics that can affect the values and perceptions of individuals within the group. Historically, certain groups have been subjected to discriminatory treatment, which causes some individuals to have a high level of sensitivity about their group identity. Examples of such cultural groups include the following:

- Gender groups: male/female
- Racial groups: distinguished by skin color and other physical characteristics
- Generational groups: generation Y (millennials), generation X, baby boomers, and the elderly
- Geographic groups: North/South; East Coast/West Coast; native cultures in Hawaii, Alaska, and on and around reservations; and areas where ethnic culture endures because large numbers of immigrants from a certain country have settled there (e.g., Mexican influences along the southern borders of Texas and California, Scandinavian heritage in Minnesota)
- Sexual preference groups: heterosexual, gay, lesbian, bisexual, and transgender
- Religious groups
- Groups based on nonracial physical characteristics: the blind, the deaf, the disabled, the obese

^bThe Healthcare Equality and Accountability Act—Family Care Act of 2005 (S 1580/HR 3561) and the Faircare Act of 2005 (S 1929). This bill was reintroduced in the Senate in 2018 as S. 2494.

- Socioeconomic groups: low income (unemployed, welfare recipients, uninsured, underinsured), middle income, affluent
- Groups with various types of family structure: singles, unmarried couples with and without children, traditional nuclear families, single mother/single father heads of households, parents with children and grandchildren, and large close-knit extended families

Culturally Significant Attitudes That May Impact Communication

The relationship between culture and communication is an integral part of our everyday lives. Our reactions and habits are learned from our parents, are passed down to our children, and largely govern the way we conduct our daily activities. Each society develops unwritten rules regarding such ordinary things as how close we stand when talking to another, where we touch another person in public, and other reflections of courtesy to those around us.

For example, it is important in many Asian societies to avoid placing another person in an embarrassing position. Harmony is to be promoted, and loud or aggressive behavior is considered a sign of poor manners. Such patients may respond more positively to a soft, quiet tone of voice than to the brisk, assertive commands so easily adopted by many Americans when they are in a hurry. When they are apprehensive or nervous, Asian patients may become reticent and unsociable, which can hinder effective communication.

The cultural differences in nonverbal behaviors are also highly significant. For example, a Vietnamese patient may smile to cover up disturbed feelings. Repeated head nods may indicate respect for the individual speaking rather than agreement with the subject being discussed. Gestures, eye contact, and touch may have unintended meanings when perceived by someone from a culture that assigns different meanings to the same signals. For example, many Native Americans avoid direct eye contact, considering it a mark of disrespect. Many Asian societies use no eye contact during verbal communication and may resent direct eye contact, perceiving it as being impolite and an invasion of personal space. In countries with a high-density population, eye contact and touch are less acceptable among adults than in the United States. Pointing directly at an individual can be considered insulting in many cultural groups, including our own, but can be especially offensive to Native Americans and certain Asian groups. Beckoning with the index finger is insulting to Filipinos and to Koreans.

In Hispanic culture, embracing, touching, and close proximity are easily accepted from familiar people. This may seem to contrast with a strong sense of modesty that can be demonstrated during physical examinations, so it is important to provide both men and women with ample gowns and covering during examinations in the imaging department. To Native Americans, personal space is very

important, and although patients may embrace or touch others with whom they feel close, touching should be confined to that needed to provide health care.

An old superstition of Mediterranean origin is occasionally seen among Hispanic clients. The “evil eye” or *mal ojo* is thought to bring bad luck or illness if children are praised or admired without also being touched. Eye contact with adults is perfectly acceptable, but when praising a child, it is wise to give a touch or pat while expressing admiration. Although the parents may no longer express belief in the “evil eye,” the ability of individuals to cause illness in a child by looking admiringly without touching is a very strong superstition.

The best way to understand people of another culture is to learn to know them personally. We hope that this discussion will heighten your awareness, not only of differences in ethnic backgrounds but also of diversity within your own cultural group. The more sensitive you become to the reactions of all your patients, the more comfortable your interpersonal contacts will be.

How Cultural Issues May Affect Care

Although this discussion is limited in scope, it should help to increase your awareness of the diversity of needs, expectations, and fears that may influence your patients in the health care setting. Box 20.3 provides some examples of how various ethnic cultural groups approach both communication and health care and how their cultural status may affect the outcome of their contacts with health care organizations. This listing is not comprehensive for all health care, but offers insight into the cultural issues that may affect patient care in imaging departments. For example, family structure may determine who makes decisions, who expects to receive information, and who usually signs documents. Although specific practices are described here in association with specific cultural groups, it is important that you understand these descriptions as broad generalizations and not use them in any way that would stereotype individuals.

Some ethnic cultures have a high level of sensitivity surrounding modesty and physical contact in health care. This may apply to any situation but is most often an issue when the patient and the health care provider are not of the same gender, especially if the patient is female and the health care professional is male. These attitudes are particularly prevalent in both Hispanic and Islamic cultures but are certainly not limited to these groups.

Religion can be a significant factor in health care as well. Religion is almost synonymous with culture in some countries. For instance, the Muslim religion predominates in the Middle East, Roman Catholicism is prevalent in Latin America, and Hinduism influences the culture of India, but all of these regions have some religious diversity as well, so it may be misleading to make assumptions about religion based on national origin. Some religious groups dictate or prohibit specific health care practices. For example, some religions do not condone blood

Box 20.3

Suggestions for Improving Communication and Care with Specific Ethnic Groups

Note that these are broad generalizations that may not apply to all members of a culture.

Anglo-American

- Patients expect to know and understand details of their conditions and treatments.
- Direct eye contact is expected; avoid excessive direct eye contact with members of the opposite sex to avoid any hint of sexual connotation.
- Emotional control is expected. Privacy is important and must be respected. Caregivers are usually welcome and expected to provide psychosocial care in addition to physical care.
- Decisions are made by individuals for themselves and may be made by either parent for a child.
- Independence is valued, and self-care concepts are generally accepted.
- Patients tend to be stoic when in pain but may also feel comfortable requesting pain medication when needed.
- Patients may prefer to be left alone when they do not feel well.
- An aggressive biomedical treatment of illness is generally preferred, but complementary and alternative medicine may also be used. Germs are thought to be the cause of illness and antibiotic treatment may be expected.

African American

- Because of a history of slavery and discrimination, African American patients may not trust “white institutions” such as hospitals and may be very easily upset by what they perceive to be discrimination. Be especially sensitive to this issue.
- Do not refer to a man as a “boy” or a woman as a “gal.” These terms are often perceived as insulting. Address individuals using their titles and last names.
- Family structure may be nuclear, extended, or matriarchal. Close friends may be a significant part of the support system. The father or eldest male may be the spokesperson and/or primary decision maker, although this authority may lie with the eldest female in a matriarchal family.
- Patients may believe that disease is caused by improper diet, exposure to cold or wind, punishment by God for sin, or voodoo spells. Cultural lore prescribes appropriate treatments for these causes. There is a rich African American tradition of herbal and home remedies.
- Many have a present-time orientation that can impede the implementation of preventive medicine and follow-up care.
- Blood or organ donation may not be acceptable except to meet the needs of family members.

Asian

- Agreement may be indicated with no intention to follow through, so it is important to explain reasons for compliance with instructions and to ask open-ended questions instead of those that can be satisfied with a yes or no answer.
- Avoid direct eye contact and hand gestures.
- Because there are no pronouns in most Asian languages, references to “he” or “she” may be confused.
- Wives may defer to husbands in decision making.
- Tremendous respect is accorded to the elderly.
- There is reluctance to admit pain.
- Traditional healing methods include coining and cupping, the use of herbs, and changes in temperature.
- Stigma is associated with mental illness, and emotional problems are not discussed with strangers. Mental or emotional problems may manifest as physical illness.

East Indian

This group includes Hindus and Muslims from India, Pakistan, Bangladesh, Sri Lanka, and Nepal.

- Direct eye contact may be perceived as rude or disrespectful, especially among the elderly.
- Silence may indicate acceptance or approval.
- Head movements may confuse those from Western cultures. A side-to-side head motion may indicate agreement or uncertainty, whereas an up-and-down nod may indicate that the listener acknowledges what the speaker is saying but does not agree.
- Husbands may answer questions addressed to their wives.
- A man should avoid shaking hands with an East Indian woman unless the woman extends her hand first.
- The father or eldest son usually has decision-making power after other family members have been consulted. Patients may not wish to participate in health care decisions, considering health care professionals to be the authorities in these matters. This may affect their willingness to sign consent forms.
- Same-sex caregivers may be preferred for reasons of modesty.
- Patients may be either stoic or expressive when in pain. Muslim patients may not want pain medication except under extreme circumstances.

Hispanic

- Because of the emphasis on personal relationships, it is helpful to ask about a patient's family and interests before focusing on health issues.
- Family members are likely to want to stay with the patient and to assist the patient with activities of daily living rather than allow these tasks to be done by professional caregivers.

- Modesty is very important, especially to older women.
- Traditional wives will defer to their husbands for decisions that involve care for themselves or their children.
- Many have a present-time orientation that can impede the implementation of preventive medicine and follow-up care.
- Patients may respond to pain with loud outcries, depending on the audience. Males may be more expressive around family members than with health professionals.
- Patients may refuse certain foods or medications that they believe will upset the body's hot/cold balance. Avoid ice water unless requested. A high fat content in food may be perceived as healthy.

Middle Eastern

- Islam is a dominant force in the lives of most Middle Easterners. Devout Muslims pray several times a day, facing Mecca (east), and appreciate privacy for this practice. They may have a fatalistic attitude about life, death, and health, believing that these matters are in the hands of Allah and that health-related practices are of little consequence.
- There is a tendency to be loud and expressive, especially during childbirth, when someone has died, and when a person is in pain.
- Family members may feel responsible for ensuring the best care possible and so may make emphatic demands of health care personnel.
- Sexual segregation is extremely important, so whenever possible, same-sex caregivers should be assigned. Every effort must be made to maintain a woman's modesty at all times. Women may not wish to remove their head scarves (hijabs), especially in the presence of men.
- Women tend to defer to their husbands for decision making involving their own and their children's health care. Husbands may answer questions addressed to their wives. When important information is sought or provided, it is considered appropriate to speak first with the family spokesperson.
- Organ donation or autopsy may not be permitted for religious reasons.
- Damp cold drafts and strong emotions are sometimes thought to cause illness. The "evil eye of envy" may also be thought to cause illness or misfortune, and amulets may be worn to prevent this; such amulets should not be removed.
- Muslims do not eat pork.

Native American

- Stories and metaphors may be used to communicate ideas. For example, a story about a neighbor who is ill may be a patient's way of describing his or her own symptoms.
- Long pauses in a conversation usually indicate that careful consideration is being given to a question. Do not rush the patient.
- Direct eye contact should be avoided, both as a show of respect and because some may feel that this threatens the loss or theft of the soul.
- Loud or aggressive behavior is considered very offensive and should be avoided.
- Historical mistreatment of Native American groups by white people, and especially the misuse of signed documents in this regard, may cause Native Americans to be leery of documents or unwilling to sign informed consents or advance directives.
- Illness of one member is a concern to all members of the family, and the extended family is very important. Patients usually make decisions for themselves, but this may vary with tribal and kinship structures. Hopi, Navajo, and Zuni tribes are matrilineal; in these groups descent is reckoned through the female line, and women or their brothers make the important decisions.
- Orientation to time is based on activities rather than the clock.
- Stoicism is valued, and patients may not express their pain other than to say they do not feel well. When a patient complains of discomfort and is not given relief, the complaint may never be repeated.
- Before cutting or shaving hair, check to see whether the patient or the family wants to keep it. In some tribes, cutting hair is associated with mourning.
- A medicine bag may be worn. Do not treat this casually or remove it without the patient's permission. If it must be removed, allow a family member to do so, keep it close to the patient, and return it as soon as possible.
- Native foods tend to be high in fat content. Foods that have been blessed (in either the traditional religion or Christianity) are believed to be free from harm.
- Use of traditional healers may be combined with the use of Western medicine. Allow traditional healers to perform rituals when possible and do not touch or casually admire their ritual objects.

Russian

The cultures of countries near Russia, particularly those of the Ukraine and Eastern Europe that were once part of the Soviet Union, are often quite similar to that of Russia today.

- Family members will be anxious about patients and will expect frequent updates about progress, treatments, and tests.
- A warm, caring attitude on the part of caregivers is especially welcome.
- Loud, abrasive demands for attention may be a reflection of the fact that this attitude was necessary to meet one's needs in the Russian health care system.
- Most patients are comfortable with direct eye contact and a firm, respectful attitude. Address patients using titles and last names. Hand gestures and facial expressions may be used by patients, especially when they are not proficient in English. Gestures and facial expressions used by caregivers may also supplement understanding.

- The gender of the caregiver is not usually an issue, but it may be desirable to have a family member of the same gender present when personal care is being performed.
- There is a tendency to have a high tolerance for pain and to be stoic in this regard.
- Many, especially the elderly, believe that illness results from cold. Therefore keep the patient covered, close windows, keep the room warm, and avoid iced drinks.

From Ehrlich RA, Coakes D: *Patient care in radiography*, ed 10, St Louis, 2020, Elsevier.

transfusions, some prohibit any practice that punctures the skin, and others oppose the practice of vaccination. Prayer and other religious healing practices may have to be accommodated in combination with medical treatments. Religious practices may influence the acceptability of certain diets or treatments and may dictate specific actions with respect to matters of life and death. Religious dietary requirements, such as kosher meals for orthodox Jews, may affect a patient's choice of medical facilities and may affect compliance with recommended health practices.

Professional Responsibility and Ethics in Relation to Diversity

You will recall from an earlier section of this chapter that issues of cultural diversity have significant ethical dimensions. The ARRT Code of Ethics requires radiographers to put aside all personal prejudice and emotional bias, rendering services to humanity with *full respect for the dignity of mankind*. Specifically, they are to conduct themselves in a professional manner, support their colleagues and associates, respond to patient needs, and deliver patient care and service unrestricted by concerns of personal attributes or the nature of the disease or illness and without discrimination on the basis of sex, race, creed, religion, or socioeconomic status.

Those who study the sociology of ethics tell us that the development of high moral and ethical standards does not come naturally to most people and is unlikely to be attained by simply reading a code of ethics or a chapter in a textbook. It is a process that begins with a commitment and continues with each encounter that presents an opportunity to listen, reflect, and learn. We must open our minds to the possibility that our own perceptions are not universal and that the differing perceptions and values of others have validity and importance.

Although understanding people of another culture is best accomplished by getting to know them personally, this may not always be practical. Many books on transcultural health care are available that can help you to bridge cultural gaps. If your geographic area has a significant number of individuals from another culture, you can enrich your life and provide better care by learning as much as possible about ethnic groups with which you come in frequent contact.

Nonverbal behaviors such as eye contact and touching are not interpreted in the same way by all those within our

own society, and the differences are even greater between one culture and another. We hope that this discussion of transcultural issues has heightened your awareness, not only of different ethnic backgrounds, but of differences within American culture as well. The more sensitive you are to the reactions of all your patients, the more comfortable your interpersonal contacts will become.

MEDICAL INFORMATION AND RECORDS

Efficient record keeping, accomplished through effective documentation of information about patients and their care, is a vital aspect of meeting patients' needs (Fig. 20.7). Attention to clerical details—such as dates, account numbers, chart numbers, Social Security numbers, and similar data—is essential to your facility and the patients it serves. Although many different forms and types of data may be used, certain terms are common.

Charting

Charting refers to any records you are expected to add to a document. In some radiology departments, the majority of the record keeping is done on requisition forms that have a limited area for charting. Others have converted all or most of their medical records to a computer system. A **chart**, paper or electronic, refers to a more extensive

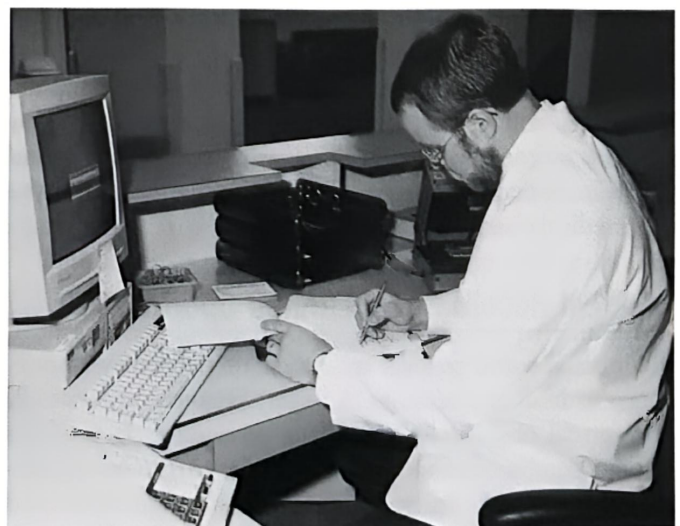


Fig. 20.7 All medical records you initiate must be pertinent, accurate, and legible.

compilation of information. Clinics keep a chart of pertinent information on each patient. These medical records include not only information on the condition of the patient, medications, and treatments, but also laboratory results, radiology reports, and other information pertaining to the health and welfare of the patient.

Health care agencies are also businesses. Proper record keeping is required to ensure that patients are billed accurately, that supplies are ordered to replace those used, and that insurance companies receive verification of the care given to their clients. Failure to process information accurately and promptly may inconvenience your coworkers and pose serious problems for patients.

The chief reason for keeping accurate, pertinent medical records is to provide data about the patient's progress and current status. Good records promote a systematic approach to therapeutic care, allowing for comparisons over time that aid in a more comprehensive approach to extended health care. The chart is a legal document that can substantiate or refute charges of negligence or malpractice and can also serve as a record of behavior. The course of treatment and quality of care are reflected in the chart.

Chart as a Resource

The need to validate your impressions when you are assessing the status of patients is discussed in Chapter 22. The chart is frequently your most accessible resource. Although the organization of charts may vary somewhat, certain elements are consistent. The diagnosis or "impression" is found at the conclusion of the history sheet. The patient's current status is found in the physician's progress notes. Allergic sensitivities are stated in the history and may also be listed in a special place or on the cover. Laboratory reports, radiology reports, and results of other studies are found in a separate section. Medication records and other standard forms will be included.

To reduce the time involved in the charting process, and the volume of medical records, charting is a somewhat streamlined form of written communication. Many frequently used words are abbreviated, and comments are made in the form of brief phrases rather than complete sentences. Some practice is needed for beginners to translate this jargon accurately. The lists of abbreviations and terms in Appendix J can be helpful to students learning to use medical charts.

Medical Recording by Limited Operators

Requisitions and reports are forms of particular importance to limited operators. An x-ray requisition serves as the formal order for a diagnostic procedure. It includes patient data, a brief medical history or reason for procedure, and specific instructions. Both the requisition and the image interpretation report are medicolegal records and may be filed with the images or separately. Although limited operators are not responsible for initiating these

records, they rely on requisitions for information about each examination they perform. They may also refer to previous reports for information about the patient's problem or recommendations for further studies.

Medical recording by limited operators varies greatly depending on the job description and place of employment. You must become familiar with your facility's requirements. Documenting certain information about patients is an essential part of maintaining a proper medicolegal record. This includes the administration of radiographic contrast media or medications, changes in patient status, reactions to radiographic contrast media or medications, and any treatment received in the health care practice environment. An example of such treatment might be oxygen given to a patient who becomes short of breath.

In some facilities, x-ray procedures are routinely charted by the limited operator. The information you chart should include the date, the time (using the 24-hour clock; for example, 2:15 PM is charted as 1415), a specific statement of what occurred, and your signature. When you are charting observations or treatments on behalf of the physician, include the physician's name, followed by a slash mark and your signature. When limited operators chart, they should use a full signature and a designation of their department or position unless their initials with their full name are recorded elsewhere in the chart for legal verification. Complete signatures are always necessary for witnessing documents such as informed consents, consents to treatment, and incident reports.

Accountability is essential to the medicolegal aspects of patient care. Whether or not your duty involves making entries in patients' charts, remember that all written records you initiate must be *accurate*, *pertinent*, and *legible*. Medical records should also be objective. For example, do not chart "patient is confused" because this does not demonstrate how you came to this conclusion. This is an unvalidated clinical judgment. "Patient cannot relate why he is at the clinic or how he got here" is a clearer, more objective statement. Objectivity is particularly important when dealing with situations that have a strong potential for legal action.

Poor medical records are often a major contributing factor when a defensible court case is lost. Charting should be complete, objective, consistent, legible, and accurate. The list in Box 20.4 alerts you to some rules for avoiding the mistakes that are frequently found when paper charts are audited.

Medical Recording on Computers

Health care providers use computers extensively for clerical functions. Unlike the business world, where each individual in an office has a personal computer, it is more common in health care facilities for computers to be strategically located and for the staff to use any computer that is convenient. Under these circumstances, using the computer system for personal communications is inappropriate.

Box 20.4

Rules for Charting in Paper Charts

- To delete an entry, simply draw a line through it; do not erase or use correction fluid.
- Always initial and date corrections.
- Never leave blanks on forms. Insert “NA” (not applicable) or “0.”
- Never insert loose or gummed slips of paper.
- Always include the year when you are dating written materials.

Your ability to log on to a computer may be protected by a password or by a barcode identification that must be scanned. These systems are used to maintain the security of all information that is stored on the computer network. The files and types of information that you are authorized to access may be limited. Be sure to log off your computer workstation when you are finished using the computer so as not to permit unauthorized access to confidential medical records. *Never give out your password or lend your barcode.*

The storage of computer data on patients creates an individual file or electronic chart, also called “e-chart,” for each patient. Access to these files supplies not only basic information about the patient, such as address, birth date, medical record number, and next of kin, but also diagnosis, test results, treatment, and other observations pertinent to patient care. E-charts reduce charting time through the use of checklists that minimize the amount of narrative recording needed. Computers are also used for scheduling, generating requisitions, billing, and entering charges when procedures have been completed. However, computers are only capable of using the information provided them. If data are incorrect or incomplete, the computer may not be able to right the error and may reject the entire entry. Your employer may provide instruction applicable to the computer systems in your facility.

Diagnostic Images as Records

Radiographs and other diagnostic images are a part of the legal medical record and are considered the property of the facility in which they are made. Patients often assume that because they have paid for the examination, the images belong to them. Tact is required when explaining that the charges cover the expense of the procedure and that every effort will be made to ensure that the images are available when necessary to assist in the patient’s care.

State laws vary with respect to the length of time that diagnostic images must legally be kept on file. Usually the retention period is 5 to 7 years, with the additional requirement that images of minors be kept 5 to 7 years after the patient reaches majority, or legal age (18 to 21 years, depending on the state).

Since rules governing confidentiality also apply to diagnostic images, the patient must sign a release form when images are needed by another provider. In the rare case where hardcopy images were produced, a written record of the date and the borrower’s name and address meets the legal obligation to release the films.

Nearly all radiographic images are now produced digitally. This simplifies the process of sending the images to a consulting physician or providing a copy to the patient. These images will be available for direct viewing by physicians with access to the picture archiving and communication system (PACS) where the images are stored. However, the majority of LXMOs work in free-standing facilities that may not be affiliated with a large health care system. In these cases, a compact disc (CD) of the images, which includes image viewing software, will be made. The CD may be given to the patient or sent directly to the consulting physician.

SUMMARY

Professional ethics are moral standards applied to professional behavior. Ethical conduct for professional radiologic technologists is prescribed by the *ARRT Standards of Ethics*. Many states have laws and regulations that define the scope of practice and provide guidelines for the professional conduct of limited operators. Ethical practice is essential to good patient care. Such conduct safeguards patient rights and reduces the likelihood of medicolegal difficulties.

Our success in any endeavor depends largely on our ability to communicate with one another. In a health care setting, many factors can cause anxiety in both patients and staff. When we approach patients with compassion and empathy, we find greater personal satisfaction in our work and improve the quality of care. The same principles of communication that increase the effectiveness of our relationships with patients and their families will enhance our relationships with coworkers.

Federal legislation addresses the patient’s right to understand and communicate effectively in health care situations, regardless of language barriers. Both legal and ethical standards require attention to the needs of patients with their cultural backgrounds taken into account. Therefore health care workers must have a general knowledge of the customs of their patients and be sensitive to any needs they may have that differ from those of the culture of the majority.

Limited operators must respect the importance of medical records and strive to keep records that are pertinent, accurate, and legible. An understanding of patient charts provides a valuable resource to validate information. The ability to chart competently is essential if the job description requires making entries in these records. Diagnostic images are a part of the legal medical record and belong to the facility in which they are taken. However, digital copies of images may be provided to the patient or to other health care providers who need them.