

Rights from Wrongs:
An Educational Unit on Patient Rights for High School Students

Honors Thesis

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Abstract

Patient rights lie at the intersection of two of the most daunting systems for everyday people, the medical and legal systems. Already stressful situations can become more confusing when a person doesn't know what protections they are entitled to as they enter a healthcare setting. Lack of awareness can be traced back to the lack of a comprehensive patient rights document in the United States. Rather, patient rights are distributed over various pieces of federal legislation, state legislation, and court cases. This paper outlines an educational unit for high school students that aims to define patient rights, outline key pieces of legislation, highlight population considerations, and identify significant legislation specific to Colorado. The goal of this unit is to help students become more familiar with the protections they are afforded in a medical setting, so they can feel more empowered when interacting with medical professionals. Through this empowerment, students will feel more comfortable seeking necessary medical help, communicating with medical professionals, and advocating for themselves if the need arises.

What are Patient Rights?

Patient rights are the ethical and legal protections a person has when receiving medical care or interacting with healthcare professionals (Olejarczyk and Young, 1-2). Patient rights fall under the umbrella of human rights, which are the minimum standards a person can expect to be treated by others. Oftentimes, rights are derived from ethics. Ethics are the standards for the ways people are expected to treat others within a given society (Olejarczyk and Young, 2). Discussions of ethics date back centuries; the first known writings about ethical obligations were found on a 24th century BCE tomb in Egypt. Ethics is commonly associated with ancient Greece

and philosophers like Aristotle, Plato, and Hippocrates (North). The legal and ethical concepts developed in these cultures continue to influence modern medical ethics and patient rights.

Medical ethics are strongly intertwined with normative ethics. Normative ethics describe how someone should behave, and is composed of virtue, deontological, and consequentialist ethics (Olejarczyk and Young, 3-4). Virtue ethics balance intent and outcome, and most directly come from Aristotle's work in the 4th century BCE. Deontological ethics relate to duty and placing a higher value on intent rather than outcome, and stem primarily from the writing of Immanuel Kant in the late 18th century. Consequentialist ethics, also known as utilitarian ethics, prioritize the outcome over the intent, and are frequently attributed to Jeremy Bentham and John Stuart Mill's writings in the 19th century. A combination of these perspectives forms modern normative ethics, creating duty virtuism. These principles are applied in the healthcare field as people expect health care providers to have certain virtues (Young and Wagner).

The core medical ethical principles are beneficence, nonmaleficence, distributive justice, autonomy, and preservation of a person's dignity (Young and Wagner). Beneficence means "bringing goodness" or, specifically in a medical setting, doing what is in the best interest of the patient throughout diagnosis and treatment (Olejarczyk and Young, 8-9). Nonmaleficence means "not bringing harm" or trying to prevent the patient from being worse after treatment than they were prior to treatment. Distributive justice means that all patients should be treated in an equitable manner. Patients with a greater need for care should be entitled to that higher level of care, as long as it does not directly limit care to those with a lesser need for care (Young and Wagner). Autonomy is the ability of a person to make their own choices according to their reasons and rationale, such as making their own choices in a treatment plan. Finally, preservation

of a person's dignity refers to treating patients with respect, compassion, and understanding and recognizing their right to live a fulfilling and meaningful life (Olejarczyk and Young, 9-12).

These core ethical principles can conflict with each other through the course of an interaction between a healthcare provider and a patient. For example, beneficence and nonmaleficence can conflict when following a course of treatment that requires harm to the body, such as surgery or chemotherapy (Olejarczyk and Young, 8-9). In these cases, the healthcare provider must weigh the potential for harm versus potential for benefit and strive to make the most ethical recommendation. Similarly, beneficence and respect for patient autonomy can conflict if a patient refuses a treatment the healthcare provider recommended (Olejarczyk and Young, 8-11). The health care provider has an ethical obligation to treat the patient in their best interest, but they must also respect the patient's autonomy. These grey areas with conflicting ethical principles are a significant challenge within the healthcare field and can often necessitate the need for legislation. The educational unit will outline these core medical ethical principles because many high school students are unfamiliar with these concepts. Establishing a foundation for the core ethical principles in medical rights will help the students understand the reasoning or basis of medical legislation that will be introduced throughout the unit.

Patient Bill of Rights

The United States does not have a consolidated list of patient rights, despite many attempts in Congress. In 1998, Congressman Charles Norwood and Congressman John Dingell sponsored the Norwood-Dingell Patients' Bill of Rights ("H.R.3605 - 105th Congress"). The Norwood-Dingell legislation would guarantee access to healthcare specialists, access to emergency room services, continuity of care if a patient's provider is dropped, access to appeals when addressing health plan grievances, open discussion of treatment options between doctors

and patients, and enforcement of compensation if a health plan's actions harm a patient. While the bill had bipartisan support, it did not pass. Many representatives, including speaker of the House Dennis Hastert, conveyed concerns about an increase in trivial lawsuits (Ciment, 1021). The Norwood-Dingell Patients' Bill of Rights, with some changes, eventually came back to Congress as the Bipartisan Patient Protection Act.

In 2001, Senator John McCain, Senator Edward Kennedy, and Senator John Edwards sponsored the Bipartisan Patient Protection Act ("S.1052 - 107th Congress"). With similar goals to the Norwood-Dingell Patients' Bill of Rights, the Bipartisan Patient Protection Act sought to protect states' rights in developing patient protections, enable more individuals to sue their health plan, and ensure access to necessary care (Benjamin, 75-77). Ultimately, the Bipartisan Patient Protection Act did not pass as a result of concerns over increasing the ability of individuals to sue their health plans. The protections set forth in the Bipartisan Patient Protection Act did not simply vanish, rather, they were spread out in Codes of Federal Regulation. In 2000, President Bill Clinton utilized his executive power to enact some of the protections covered in the Bipartisan Patient Protection Act in CFR titles 26, 29, and 45, dealing with Taxes, Labor, and Public Welfare respectively (Olejarczyk and Young, 7). Having these protections in place is beneficial, but there is still a lack of a central document describing the rights of patients.

Several organizations have created their own Patient's Bill of Rights or ethical guidelines for physicians. While these documents are not legally enforceable through the U.S. court systems, they can still serve as valuable resources for patients. In 1973, the American Hospital Association developed a Patient's Bill of Rights ("The Patient Care Partnership"). This document was revised in 2003 and is currently in the form of an accessible, plain-language Patient Care Partnership brochure. The goal of the Patient Care Partnership is to outline what a patient can

expect while staying in the hospital. These expectations include: high quality hospital care, a clean and safe environment, involvement in care, protection of privacy, help when leaving the hospital, and help with billing claims (“The Patient Care Partnership”). Similarly, the American Medical Association has a Medical Code of Ethics that is meant to guide ethical medical practices. The Code of Medical Ethics was first formed in 1847 with the establishment of the American Medical Association (“AMA Medical Code of Ethics”). The core principles of the Code of Medical Ethics are: practicing patient-centered care, maintaining professional integrity, commitment to public health and social responsibility, and being a living document. The Code of Medical Ethics has been revised numerous times since 1847 to reflect changes in ethical priorities as well as technological advances. Although these documents are not legally enforceable, there are oftentimes pieces of legislation associated with principles they outline.

Health Insurance Portability and Accountability Act

In 1996, the federal government passed the Health Insurance Portability and Accountability Act (HIPAA) in Title 45 of Code of Federal Regulations (“HIPAA of 1996”). The primary goal of HIPAA is to create national standards for the protection of confidential medical records. Prior to the implementation of HIPAA, federal regulations lacked clarity and consistency, so state and federal requirements for privacy protection often differed. HIPAA guarantees all patients the right to privacy, confidential use of their medical information, the ability to access and amend their health information upon request, provide specific authorization for the use of their medical information for purposes other than treatment and billing, and have their name withheld from patient directories or account lists. (Moore and Frye, 269). In accordance with HIPAA, every patient must receive a Notice of Privacy Practices. The HIPAA Notice of Privacy Practices is a document that describes how a HIPAA covered entity can use or

disclose protected health information (PHI), and it must include the patient's rights, the covered entity's legal duties concerning PHI, and the contact information for questions or complaints (Adler). The details can vary depending on the covered entity, each Notice of Privacy Practice should contain this information.

The main principles of HIPAA are the privacy rule and the security rule, as described by Wilnellys Moore and Sarah Frye. The privacy rule is the obligation of authorized persons using PHI to keep that information secret, and the minimum national standards covered entities must follow to protect private medical information. Covered entities include health plans, billing companies, healthcare providers, and business associates. Furthermore, the privacy rule establishes that patients have a right to request copies of their health records and radiographic images and must receive these within 30 days of the request, by law (Moore and Frye, 270-271). The security rule refers to the procedures designed to prevent unauthorized persons from accessing PHI through physical, technical, and administrative safeguards. Physical safeguards detail the protection of the location or physical objects containing PHI. Technical safeguards discuss the control of access to computer systems and the protection of PHI that is transmitted electronically. Administrative safeguards require the facility to create and update policies for employees to practice in order to help ensure the security of PHI (Moore and Frye, 271-272). However, there are cases when PHI must be shared.

HIPAA entities may not disclose PHI unless it is authorized by the patient in writing, but there are exceptions when written permission is not needed. PHI can be shared for treatment, payment, and general health-care operations, but only information necessary to the task can be shared (Moore and Frye, 271). Substance abuse records from a licensed abuse program and written psychotherapy notes are the only clinical information that cannot be shared without the

patient's explicit consent. If the patient can agree or object to the disclosure of PHI and willingly consents to the disclosure, then PHI can be shared. During natural disasters, certain elements of the HIPAA can be waived by the president or state officials for the implementation of disaster protocols in the area (Moore and Frye, 271). PHI can be disclosed for public health activities and purposes, such as preventing the spread of a disease or receiving reports of child abuse. Finally, covered entities can disclose PHI without written patient consent if requested by a court order.

Emergency Medical Treatment and Labor Act

Congress passed the Emergency Medicine Treatment and Active Labor Act (EMTALA) in 1986. The purpose of EMTALA is to try to prevent patient dumping, which is a form of discrimination against uninsured or underinsured patients (Warby 1). Patient dumping is when a patient is involuntarily moved to another hospital without being properly evaluated for their emergent condition due to financial reasons. Instances of patient dumping most commonly occurred in larger cities with private hospitals transferring uninsured and underinsured patients to public hospitals. Any U.S. hospital that accepts payment from the Department of Health and Human Services and the Centers for Medicare and Medicaid Services must comply with EMTALA, and this applies to 98% of hospitals (Warby, 1). Hospitals that fall under EMTALA have three legal responsibilities.

The first legal responsibility is hospitals with an emergency department must provide an appropriate medical screening examination to any person requesting examination or treatment for a medical condition to determine if there is an emergency medical condition present (“42 U.S. Code”). EMTALA covers all patients in the emergency department with a potential emergency medical condition, not just those with Medicare (Warby, 1-2). This rule applies to the emergency department, the hospital's entire property, and ambulances that are owned and

operated by hospitals. The medical screening examination must be performed by qualified medical personnel, but EMTALA does not necessarily define what constitutes “qualified medical personnel.” The second legal responsibility is if the patient has an emergency medical condition, the hospital must stabilize and treat the patient, regardless of ability to pay, age, race, ethnicity, disability, immigration status, insurance coverage, or national origin (“42 U.S. Code”). The same screening procedures and treatments must be used for all patients that present with similar signs and symptoms. The hospital can then transfer the patient to another medical facility once the patient has been stabilized and the guidelines set by EMTALA have been met (Warby, 2-3). The only time a medically unstable patient can be transferred is if the patient requests the transfer and a physician determines that the benefits of the transfer outweigh the risks. The third legal responsibility is hospitals with specialized services must accept patients in need of those services (“42 U.S. Code”). When the emergency department contacts specialized services, like a burn unit, they cannot ask questions about insurance coverage and cannot refuse a transfer if they have the space and ability to care for the patient (Warby, 3-4).

Consent and Medical Capacity

Informed consent is the measures a healthcare professional takes in helping their patient understand the risks, benefits, and alternatives through the course of treatment (Shah, 1). The process of obtaining informed consent from a patient protects patient rights, increases transparency, and helps to encourage trust between the healthcare profession and their patient. In the U.S., court cases are largely responsible for the advancement of patient rights with informed consent. The case of *Canterbury v. Spence*, in 1972, established that patients must be informed of any risk of harm if it could entail death or a life-altering complication, even if the risk is only a 1% chance (Olejarczyk and Young, 13-14). The right to informed consent is codified in multiple

Codes of Federal Regulation, stating “(T)he patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status (and) being involved in care planning and treatment...” as described by Olejarczyk and Young. While the statutes for informed consent can vary by state, the specific minimums that must be included while obtaining consent are the therapy’s nature, benefits, risks, and reasonable alternatives, in addition to the assessment of the patient’s capacity. Some exceptions to informed consent include when the patient is incapacitated, life-threatening emergencies, and when consent is voluntarily waived (Shah, 6).

In order to provide informed consent, a patient must demonstrate that they have medical decision-making capacity. The key elements of medical decision-making capacity are demonstrating an understanding of the benefits, risks, and alternatives for a proposed treatment; demonstrating a recognition of those benefits, risks, and alternatives; showing reasoning in deciding; and communicating their choice (Barstow, 40). In general, a physician can readily determine a patient’s capacity during routine interactions and communications with the patient. If the physician feels the patient may not have the capacity to make medical decisions, they will move on to a formal assessment with tools such as the Aid to Capacity Evaluation or the Hopkins Competency Assessment Test (Barstow, 40-42). In the case that the physician decides a patient does not have medical capacity, consent for treatment must be obtained through other sources. These other sources can be a designated medical power of attorney or, if there is no medical power of attorney, a relative typically becomes the surrogate. The priority of which relative becomes surrogate can change depending on the state, but it typically follows the order of spouse, adult children, parents, siblings, and other relatives (Barstow, 45).

Population Considerations

In most situations, children younger than 18 are not considered to be capable of providing informed consent, and parents or legal guardians must consent to treatments (Shah, 6). However, there are exceptions as children reach adolescence and begin to display maturity. Minor consent and medical emancipation statutes give minors permission to consent to treatments based on their status or the service they are seeking (Hickey, 100). A minor may provide consent without parental consent if they are: a pregnant minor, a married minor, a minor in the armed services, a minor with a child, a minor living apart from parents that demonstrates financial self-reliance, or a minor that is a victim of sexual assault or abuse. A minor may provide consent without parental consent if the service they are seeking is venereal disease treatment, HIV testing, contraception, prenatal care, abortion, mental health treatment, emergency care, or alcohol or drug abuse after 12 years old (Hickey, 102). Some states recognize the “Mature Minor Doctrine,” which is when a minor is deemed capable of understanding all the consequences of a medical treatment and is considered able to provide informed consent. The mature minor doctrine allows minors to consent to treatment if: they are a minor that is fourteen years or older, they are capable of giving informed consent, the treatment will be beneficial, the treatment does not present great risk, and the treatment is within established medical protocol (Hickey, 102). Minors’ rights in medical decision making are complex because they can vary by state and often have vague definitions, so it is important to consult state legislation.

Undocumented immigrants are people that have entered the U.S. without documents or authorization, remain in the U.S. after their authorization has expired, or have an unresolved application for immigrant status (Beck, 1). Many undocumented immigrants face fear of being reported to Immigration and Customs Enforcement (ICE) while trying to receive medical care.

Undocumented immigrants are protected in healthcare settings under HIPAA and EMTALA (Hoke and Lowrey). One of the most significant pieces of protection in medical settings for undocumented immigrants is that they are not required to provide any immigration status information to a medical provider. Under HIPAA, protected health information that can be used to identify a patient cannot be shared without consent. A patient's immigration status or country of origin is not technically considered identifying information. However, this information is protected under HIPAA if it is used with other identifying information, such as the patient's name or address (Hoke and Lowrey). Therefore, a healthcare professional cannot share someone's name and immigration status without consent or exigent circumstances.

Undocumented immigrants are protected under EMTALA because hospitals must stabilize patients in emergency situations, regardless of their immigration status or insurance coverage ("42 U.S. Code"). While these protections are vital in ensuring access to medical care, undocumented immigrants often face barriers when trying to utilize the legal system if a violation does occur.

Colorado Legislation

While not directly related to patient rights, Colorado's 911 Good Samaritan Law has significant impacts on the process of reporting an overdose and protection of those involved. Colorado Revised Statute § 18-1-711 (2024), commonly known as the 911 Good Samaritan Law, provides protections from criminal prosecution for an offense associated with an overdose event if the person follows specific steps ("2021 Colorado Code"). The person must report the emergency overdose event to a law enforcement officer, 911, or a medical provider, or must seek help for the person that is overdosing. The reporting person is also required to stay at the scene until a law enforcement officer or medical responder arrives or stay at the medical facility until a

law enforcement officer arrives. Finally, the person reporting must identify themselves and cooperate with the responding party. The person who suffered the overdose event is also entitled to this immunity if these steps are taken. However, there are limitations to the 911 Good Samaritan Law depending on the possession or distribution amounts of the substance (“2021 Colorado Code”). Ensuring a comprehensive understanding of the Colorado 911 Good Samaritan Law is vital for high school students in Colorado, because many may fear the legal consequences for themselves or the person experiencing the overdose. Reducing fear or confusion from reporting an overdose can encourage students to take appropriate or life-saving action if needed.

Educational Unit

When visiting a healthcare professional, individuals typically do not have the time nor the ability to search through countless confusing government documents in order to find the protections they are entitled to through the course of their treatment. Young adults especially face confusion as they begin to navigate the interactions in the medical world without the assistance of their parents or guardians. This confusion can create fear, avoidance, and lack of communication with medical professionals, leading to a lack or a complete absence of appropriate medical care. One way to mitigate this confusion and lack of knowledge would be the implementation of an educational unit on patient rights in high school health classes. A one-week lesson plan focusing on key medical legal legislation would help high school students become more familiar with the protections they are afforded while receiving care from health professionals. The educational unit on patient rights would encourage high school students and young adults to be more active and knowledgeable about their own medical care.

Learning Objectives

The educational unit aligns with Comprehensive Health and Physical Education Standard 2: Physical and Personal Wellness, Standard 3: Social and Emotional Wellness, and Standard 4: Prevention and Risk Management, as described by the Colorado Academic Standards (“2020 CAS”). Standard 2: Physical and Personal Wellness focuses on providing students with the skills and knowledge to make informed decisions about their health and improve communication skills for personal wellness. Standard 3: Social and Emotional Wellness focuses on making responsible decisions, handling stressful situations, and establishing positive relationships. Standard 4: Prevention and Risk Management focuses on personal safety skills and health-enhancing decisions regarding the use of drugs. The educational unit assists with these objectives by educating students on their rights, which leads to more informed decisions within their health care, increased communication with medical professionals, and higher awareness of rights and resources in emergency situations.

The learning objectives of the educational unit apply to the key medical legislative pieces covered within the unit. Students should be able to describe the basic principles that serve as the basis for the “Patient Bill of Rights,” describe what is protected by the “Patient Bill of Rights,” and analyze a healthcare-based scenario and apply concepts from the “Patient Bill of Rights.” Students should be able to describe what rights are afforded to patients under HIPPA, describe when a medical professional is required to maintain confidentiality, and identify scenarios in which a medical professional is able to disclose their protected health information. Students should be able to define the concept of informed consent and what qualifies as informed consent and describe medical capacity and identify what defines a patient “capable” of making a medical decision. Students should be able to identify situations in which a patient is entitled to emergency

medical care, regardless of ability to pay, as described by EMTALA. Students should be able to describe how the rights of a patient can vary when it comes to different populations of people, such as minors or undocumented people. Finally, students should be able to identify statutes that are unique to Colorado, such as the 911 Good Samaritan Law, and students should be able to navigate resources in order to evaluate how patient rights can be determined on a state-to-state basis.

Instructional Materials

The primary instructional materials of the educational unit will be lectures on key pieces of patient rights legislation. Lecture one will outline the primary concepts of various patient bills of rights and applications in the U.S. Lecture two will focus on HIPAA protections, consent, and medical capacity. Lecture three will describe EMTALA and considerations for specific populations, such as undocumented people, the LGBTQIA+ community, and minors. Lecture four will dive into specific pieces of legislation that are unique to Colorado and their applications. The lectures will include in-class activities designed to increase student engagement and application of concepts. During lecture two, students will act out scenarios and identify breaches of HIPAA. At the end of lecture three, students will participate in a game-like competition, such as Kahoot or Quizlet Live, which will also help identify potential topics that need clarification. In lecture four, students break into small groups and compare medical rights of minors between Colorado and a state of their choice. It is recommended that students use the “Minor Consent and Confidentiality: A Compendium of State and Federal Laws” created by the National Center for Youth Law.

The assessment methods of the unit will consist of a pre-lecture quiz, a post-lecture quiz, and a country comparison homework. The pre-lecture quiz will be an ungraded multiple-choice

quiz about the information that will be covered in the unit, and it will be given at the start of the unit prior to lecture content. This quiz will provide a gauge of the starting point of knowledge for students, and it will give students the opportunity to see the concepts and try to make critical connections before the lectures. The post-lecture quiz will be multiple choice questions from the pre-lecture quiz in addition to other content covered in the unit. This quiz will be an opportunity to evaluate what students have learned and identify potential gaps in the education unit. The country comparison homework is an assignment that will have students compare and contrast patient rights in the U.S. and another country of their choosing. This assignment will give students the opportunity to practice navigating legal resources and apply the knowledge they have learned in class. The country comparison homework can be given as a worksheet or as a compare-contrast essay, depending on the grade-level and ability of the students.

Conclusion

Patient rights in the U.S. are considered to be a convoluted concept for the average person because there is no central document describing patient rights. An educational unit for high school students on patient rights would provide a consolidated resource about their rights in medical settings, which would help students feel more comfortable and empowered while receiving medical care. The unit would focus on medical ethics principles, the Patient Bill of Rights, HIPAA, EMTALA, consent, medical capacity, and population considerations.

Implementing the one-week education unit in health classes would help students meet the Colorado Academic Standards for Comprehensive Health. Through lectures, quizzes, in-class activities, scenarios, and homework assignments, students will solidify their understanding of patient rights and be able to develop independence and confidence as they begin to make their own medical decisions.

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Course Resources

Contents:

Learning Objectives	20-21
Standards Alignment	22
Schedule.....	23-24
Assessment Methods	25
Instructional Activities	26
Supplemental Resources	27

Learning Objectives

Patient Bill of Rights:

- Students should be able to describe the basic principles that serve as the basis for the “Patient Bill of Rights.”
- Students should be able to describe what is protected by the “Patient Bill of Rights.”
- Students should be able to analyze a healthcare-based scenario and apply concepts from the “Patient Bill of Rights.”

Privacy and Health Insurance Portability and Accountability Act (HIPAA):

- Students should be able to describe what rights are afforded to patients under HIPAA.
- Students should be able to describe when a medical professional is required to maintain confidentiality.
- Students should be able to identify scenarios in which a medical professional is able to disclose their protected health information.

Consent and Medical Capacity

- Students should be able to define the concept of informed consent and what qualifies as informed consent.
- Students should be able to describe medical capacity and identify what defines a patient “capable” of making a medical decision.

Entitlement to Treatment and the Emergency Medical Treatment and Active Labor Act (EMTALA):

- Students should be able to identify situations in which a patient is entitled to medical care, regardless of ability to pay.

Population Considerations:

- Students should be able to describe how the rights of a patient can vary when it comes to different populations of people, such as minors or undocumented people.

State of Colorado:

- Students should be able to identify statutes that are unique to Colorado, such as the 911 Good Samaritan Law.
- Students should be able to navigate resources in order to evaluate how patient rights can be determined on a state-to-state basis.

Standards Alignment

Colorado Academic Standards for Comprehensive Health as established by the Colorado Department of Education. <https://www.cde.state.co.us/cohealth/2020cas-ch-hs>

Standard 2. Physical and Personal Wellness

2. Apply knowledge and skills necessary to make personal decisions that promote healthy relationships and sexual and reproductive health.
3. Apply knowledge and skills related to health promotion, disease prevention, and health maintenance.

Standard 3. Social and Emotional Wellness

4. Utilize knowledge and skills to enhance mental, emotional, and social well-being.

Standard 4. Prevention and Risk Management

5. Apply knowledge and skills to make health-enhancing decisions regarding the use of marijuana, illegal drugs, prescription drugs, alcohol, and tobacco.
7. Apply personal safety knowledge and skills to prevent and treat injury.

Schedule

Day 1:

- Administer the pre-lecture quiz.
 - Remind students that this portion is ungraded and simply serves to act as a gauge for previous knowledge.
 - Students are not expected to know the answers, but the pre-lecture quiz gives them an opportunity to see concepts and begin to form an idea of what they will be learning.
 - Allow 15 to 25 minutes for the pre-lecture quiz, depending on class schedule time and needs of the students.
- Begin lecturing on Lecture Part I, focusing on the “Patient Bill of Rights” learning objectives and generally outlining patient rights and the laws they are derived from.
 - This lecture will be shorter, providing more time for the pre-lecture quiz.
 - To further engage students, ask if they can think of any patient rights on the indicated slide show.

Day 2:

- Start lecturing on Lecture Part II, focusing on “Privacy and HIPAA Protections” and “Consent and Medical Capacity” learning objectives.
 - This lecture will be longer, one of the primary content days.
 - To further engage students, have them act out scenarios and ask them to identify breaches of HIPAA.

Day 3:

- Start lecturing on Lecture Part III, focusing on “Entitlement to EMTALA” and “Population Considerations” learning objectives.
 - This lecture will be longer, one of the primary content days.
- To further engage students, at the end of the lecture content, have the students participate in a Quizlet Live or Kahoot. Also allows a check-in and clarification for potentially confusing topics.

Day 4:

- Start lecturing on Lecture Part IV, focusing on “Applications in Colorado” learning objective. This will be the final lecture of the unit.
- Have the students break into small groups and have them choose a state. Using the “Minor Consent and Confidentiality: A Compendium of State and Federal Laws” and other resources, the student will prepare a list of similarities and differences between Colorado and their state of choice.

Day 5:

- Administer the post-lecture assessment.
 - Remind students that this portion is for a grade.
 - Allow more time for the post-lecture assessment. Students will need more time to answer questions because they should now be familiar with the content.
- Administer the end of unit questionnaire.
 - This will allow students to give feedback on topics they found confusing, topics they want to know more about, and topics they wish were covered.

Assessment Methods

Pre-Lecture Quiz

- An ungraded quiz given to gauge the starting point of knowledge for students and provide a point of comparison after the unit.
- 15 multiple choice questions on content that will be covered in the unit.
- This will give students the opportunity to see concepts and try to make critical connections before the lesson.
- Allow 15 to 25 minutes for students to take the pre-lecture quiz, depending on the needs of the class and schedule.

Post-Lecture Assessment

- A graded assessment to evaluate the student's understanding of the unit and the effectiveness of the unit itself.
- 30 multiple choice questions on content that has been covered in the unit.
- Some questions will be repeated from the pre-lecture quiz to directly compare understanding before and after the unit.

Country Comparison Homework

- Students will compare and contrast patient rights in the United States and another country of their choosing.
- This will give students the opportunity to practice navigating legal resources and applying knowledge they have learned in class.
- The assignment can be formatted as a worksheet for students to fill out or a compare-contrast essay, depending on the level of the class.
- Due two to three days after the conclusion of the unit.

Instructional Activities

Compare and Contrast with Other States

- Have students separate into small groups and research patient rights for minors in another state of their choosing.
- Form a brief list to share with the class, describing some similarities and differences between patient rights in Colorado and their state of choice.
- It is recommended that students use the “Minor Consent and Confidentiality: A Compendium of State and Federal Laws” created by the National Center for Youth Law.
- This activity is designed to give students the opportunity to apply legal concepts they have learned and practice navigating legal resources.

Question Competition

- Using multiple choice questions on content from the unit and questions from the quizzes, the students will participate in a Quizlet Live, Kahoot, or similar game format.
- Competitive games help to engage students, encourage application of knowledge, and give real-time feedback to students and teachers about which content areas may be weak.
- This is also an opportunity for the instructor to clarify any topics that may be confusing to a significant portion of the students.

Scenarios

- Students will be provided dialogue cards and act out different scenarios about patient rights in front of the class.
- Other students identify any issue with the scenario and correct the issues they notice.
- This an opportunity for students to actively engage with the content they are learning and practice observing breaches of patient rights.

Supplemental Resources

Minor Consent and Confidentiality: A Compendium of State and Federal Laws

<https://www.teenhealthlaw.org/state-federal-compendium>

- This resource provides definitions on applicable terms, expands on how specific topics can apply to minors, and lists how rights vary with each state.

AMA Code of Ethics

<https://code-medical-ethics.ama-assn.org/chapters>

- This resource outlines the ethical guidelines that physicians are expected to follow.
- By exploring this website, students can learn what ethical guidelines physicians are expected to follow and how this can impact their interactions with medical professionals.

AHA Patient Care Partnership

<https://www.aha.org/other-resources/patient-care-partnership>

- This resource describes what patients can expect while staying in the hospital.
- Students can use this website to learn about their rights and responsibilities in the hospital with a plain language brochure.

Code of Federal Regulations

<https://www.ecfr.gov/>

- This resource compiles all Federal Regulations.
- If students want to learn more about a specific CFR mentioned in the lecture, they can use this resource for further research.