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Question 1: hospital resource management ?

Resource management in healthcare can be overwhelming for even the most seasoned of management staff.

Your hospital must be open 7 days a week. You must have dozens (if not hundreds or even thousands) of employees on-hand, ranging from clinicians to vital support staff. You must also manage multiple complex patient needs and, above all, prevent even the tiniest detail from falling through the cracks.

This is an incredibly intricate puzzle of prioritization — and lives are at stake.

That’s why you need all the help you can get in setting the right priorities and implementing the most effective practices. Here are are 5 tips to get you started.

**Tips for Resource Management in Healthcare**



**1. Prioritize Visibility to Create Accountability**

It is difficult to keep everything in mind, even when writing something as inconsequential as a grocery list.

That is why we suggest **investing in a dashboard**that allows you to make everything, from employee schedules to key metrics, [**visible**](https://www.vorex.com/top-5-best-practices-for-project-and-resource-management-in-healthcare-orgs/)**to everyone who needs to see it**.

With a dashboard available for review during staff meetings, and available for a glance at the beginning of shifts and throughout the day, your team will ensure that tasks are completed in multiple, simultaneously-running projects.

Positive outcomes of this strategy involve lowering costs by reducing redundant spending and idle staff time.

**2. Inventorize and Ration All Resources**

In order to ensure all resources (from staff time to tools and materials) are used as efficiently as possible, a number of hospitals**are implementing the**[**just-in-time**](https://digitalcommons.wku.edu/cgi/viewcontent.cgi?referer=https://www.google.com/&httpsredir=1&article=1537&context=stu_hon_theses)**(JIT) model**.

The JIT model involves producing only what is needed when it is needed.

Originally applied to car manufacturing, the JIT model advises organizations to*only* keep staff and resources that are needed **in the near-term to reach your objectives**.

This way, the JIT model ensures that your inventory is never overstocked and, in turn, prevent waste or overspending.

In a [healthcare JIT model](https://pdfs.semanticscholar.org/0879/c118f70e28b0e759e39f45db2b1129e46267.pdf), **‘inventory’ and ‘waste’ includes materials but also involves optimizing and eliminating waste from human-led processes,**such as minimizing unproductive time through better schedule planning and eliminating redundancy and errors (which can detract from ‘value’ and patient satisfaction).

On a [larger scale](https://www.nbcbayarea.com/news/local/Santa-Clara-Valley-Medical-Center-Turner-Construction-323284481.html), the JIT method can ensure that institutional improvement and development is kept realistic and timely.

**3. Guard Your Data (Information is a Resource Too)**

One huge aspect of resource management in healthcare involves handling patient data.

Given the sheer amount of highly personal patient information hospitals possess, data breaches in healthcare sound terrifying, don’t they?

Unfortunately, especially given the gradual switch from paper-based to electronic health records (EHR), healthcare data breaches [do happen](http://www.healthcarebusinesstech.com/best-practices-to-secure-healthcare-data/), and recovering from them costs time and money.

In addition, regulators will level costly fines — with the average [breach fine](https://resources.infosecinstitute.com/category/healthcare-information-security/security-awareness-for-healthcare-professionals/#gref) costing $1,500.

Take the time to develop and implement training sessions for educating staff using proper data protection protocol. You might also [consider](http://healthcaretechreview.com/i-security-mistakes-most-hospitals-make/) strong digital protection to keep your data as safe as possible.

**4. Choose the Team Over the Individual**

Healthcare requires efficient teams working in tandem with other teams: nurses with doctors, for example.

Research shows that healthcare resource management professionals should [prioritize](https://www.purchasing-procurement-center.com/hospital-materials-management.html) team-oriented objectives over those of individuals (such as the needs of a ‘star’ surgeon).

**5. Improve Relationship Management With Staff**

Research [finds that](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5029057/) management-level healthcare workers often**manage their staff through behavior control**.

This is an antiquated method of managing employees through simply issuing commands.

However, this method of management [tends to](https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-016-0149-0) instill negative feelings in staff both towards their job and their managers. It can lead to a toxic working environment, resentment, and ultimately, burnout.

Hospital staff are arguably the most valuable ‘resources’ in a healthcare organization, and management is therefore advised to **decrease behavior control and instead focus on increasing levels of staff input/output.**

This system prioritizes **milestone and goal oriented approaches** over behavioral control (or micro-management), often resulting in more positive workplace attitudes and higher quality of work.

From managing ongoing patient needs to ensuring staff have the tools and training they need, resource management in healthcare is a huge and complex undertaking for management staff.

Maintaining visibility, emphasizing the team over the individual, and nurturing positive relationships with staff are key points for optimal resource management.

**Conclusion**

There’s one common element that ties most of these tips together; in a healthcare environment, *people* are your most important resource.

It is thus advisable to focus your efforts on improving the productivity and efficiency of your staff. Your biggest operational issues can often be solved by optimizing scheduling, and reducing non-productive time in your facility. And if you’re running a well oiled machine from a staffing perspective — there’s still room to [improve overall productivity](https://www.bfwinc.com/5-not-so-simple-methods-for-improving-physician-productivity-in-hospitals/) in your organization

**Question 2 Health care law and privacy concern?**

**Answer”: Privacy in healthcare**. **Privacy** in a **healthcare** situation means that what you tell your **healthcare** provider, what they write down about you, any medication you take and all other personal information is kept private

**PRIVACY IN HEALTHCARE**

Privacy is a rich concept with a major role in the assessment of healthcare practices, policies, and law. It has become increasingly commonplace to ascribe important health-related privacy interests to individuals, families, and institutions and then to criticize public and private sector failures to protect those interests.

**Privacy and Health Services**

The word *privacy* has four major usages, corresponding to four distinct forms, dimensions, or conceptions of privacy: physical privacy, informational privacy, proprietary privacy, and decisional privacy. Issues relating to all four pervade healthcare

**PHYSICAL PRIVACY.** Under one popular usage of the term, *privacy* denotes freedom from contact with other people. The desire for limited physical accessibility—for seclusion and solitude conducive to peace of mind and intimacy—is a desire for privacy in this first sense. Members of the general public regard many social, business, and governmental contacts as privacy intrusions. These include door-to-door, street corner, telephone, and mail solicitation; some forms of sexual harassment; beeper and [cellular telephone](https://www.encyclopedia.com/science-and-technology/computers-and-electrical-engineering/electrical-engineering/cellular) monitoring; and employers' performance, polygraph, drug, and alcohol testing. Common governmental practices are controversial for their threats to physical privacy, especially the use in foreign intelligence gathering and domestic surveillance of high-powered binoculars, concealed tape recorders, cameras, wiretaps, and thermal imaging. The loss of physical privacy is sometimes a concern when criminal-justice officials rely on body-cavity searches, prison-cell searches, and electronic monitoring of probationers; or when the police operate "checkpoints" to detect violations of curfew, seat-belt, drug, and drunk-driving laws.

Complete physical privacy is inconsistent with the demands of modern healthcare. The modern delivery of health services presupposes that patients and medical professionals mutually accept nudity, touching, and observation as unavoidable aspects of examination, treatment, surgery, and hospitalization. Typical patients willingly sacrifice the desire for bodily concealment and seclusion for a chance at better health. Yet patients often expect their physicians, nurses, and other caretakers to guard assiduously against unnecessary bodily exposure or contact. The examination gowns and pajamas worn by patients respond to the expectation of privacy, as well as the need for warmth.

Hospital patients—and their lawyers—have sometimes characterized unauthorized medical treatments as invasions of privacy, along with the bedside presence of inessential medical attendants, spectators, or cameras. The desire for physical privacy may lead patients who have a choice to select single over shared hospital rooms. Because for many Americans bodily exposure to persons of the opposite sex is a more significant loss of privacy than same-sex exposures, the desire for physical privacy has led some patients to prefer physicians or nurses of their own sex. Norms of quietude surrounding hospitals reflect the sentiment that patients have heightened physical and psychological needs for solitude and peace of mind.

**INFORMATIONAL PRIVACY.** Under a second popular usage, *privacy* is synonymous with secrecy, confidentiality, data protection, or anonymity. It requires limits on the accessibility of personal information. The expectations of privacy surrounding health information are especially high, but not unique. Significant expectations of privacy exist also for information related to employment, education, Social Security numbers, criminal arrest, library use, video rentals, motor vehicle registration, taxes, consumer credit, and banking.

Informational privacy concerns in the healthcare setting have traditionally focused on the confidentiality of the physician–patient relationship and on limiting access to medical and insurance records. The willingness of patients to speak openly about physical and mental health concerns depends, in part, on expectations of professional confidentiality. The administrative demands of managed care interject faceless decision makers into the context of physician care at a cost to privacy. Proposals for governmentally or institutionally mandated testing, reporting, and identification raise other informational privacy concerns. The [public health](https://www.encyclopedia.com/medicine/divisions-diagnostics-and-procedures/medicine/public-health) community recognizes the potential threat to privacy and other important interests posed by nonanonymous AIDS testing or reporting and mandatory medical insurance identification cards.

Informational privacy in healthcare is not solely a matter of safeguarding information about individuals. By virtue of genetic ties, family members may share health conditions or predispositions. Progress by researchers toward the goal of mapping and sequencing the human genome has heightened ethical concerns about possible family, as opposed to individual, privacy interests in the information coded in a person's genetic materials (Powers).

Informational privacy requires appropriate forms of secrecy, sometimes defined as intentional concealment of fact (Bok); and confidentiality, defined as selective disclosure of fact to authorized persons (Allen, 1988). In institutional settings security requires mechanisms capable of limiting access to information, such as locked office doors and file cabinets. The security of health data shared on computers may require user identification passwords and encoding. In addition to security, concern about privacy of information overlaps with concern about what are sometimes called "fair information" practices. These include maintaining accurate information in confidence. The accuracy and security of information contained in health, insurance, adoption, and gene-research records potentially bears on the quality of healthcare and therefore holds special importance.

Managed care, the AIDS epidemic, and the [Human Genome Project](https://www.encyclopedia.com/science-and-technology/biology-and-genetics/genetics-and-genetic-engineering/human-genome-project) spawned numerous proposals for federal and state regulations governing health information. The [federal government](https://www.encyclopedia.com/social-sciences-and-law/political-science-and-government/political-science-terms-and-concepts-28) responded with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA included provisions encouraging uniform electronic transfer of medical information and required modern safeguards to protect both the security and confidentiality of medical data. HIPPA's initial privacy standards went into effect in April 2001 and did not preempt stronger state law privacy standards.

HIPAA covers government and private health plans, healthcare clearinghouses, and many healthcare-related service providers, such as firms that take care of patient billing. These firms must adopt privacy policies and inform patients of their privacy rights. They must also train staff to respect privacy and designate a privacy officer charged with privacy oversight responsibilities.

HIPAA requires special protections for individually identifiable health information disclosed orally, on paper, or electronically. Patients must be given notice of their privacy rights, access to their medical records, and a right to limit disclosures to third parties, subject to certain exceptions. For example, patients do not have the right under HIPAA to veto access to their medical records by [public health](https://www.encyclopedia.com/medicine/divisions-diagnostics-and-procedures/medicine/public-health) officials, researchers, the courts, or emergency medical personnel or in certain other situations. Only psychotherapy notes used and created by psychotherapists are accorded a higher level of protection. Patients do have rights against the unauthorized disclosure of their medical information to third parties for employment personnel or marketing purposes. Although HIPAA does not authorize patients to sue for violations, it places enforcement powers in the hands of the Department of Health and Human Services, which may seek civil penalties and criminal punishments up to $250,000 and ten years in prison for the most egregious knowing violations of the statute.

**PROPRIETARY PRIVACY.** Concerns relating to the appropriation and ownership of human personality are increasingly framed as privacy concerns. Under a third usage, privacy can mean the appropriation of a repository of personal identity. These concerns have emerged in healthcare and health-research-related domains. According to American [common law](https://www.encyclopedia.com/social-sciences-and-law/law/law-divisions-and-codes/common-law) now recognized in a majority of states, to appropriate a person's name, likeness, or identity is a way of invading that person's privacy. Following this precedent, patients photographed without their consent may object to publication on privacy grounds. Moreover, because a person's genes are widely believed to be biologic keys to personal identity and sources of health information that should be properly controlled by the individual, a person whose DNA is appropriated without consent may likewise object on privacy grounds. In the 1990s, when the U.S. military first required active duty service members to undergo tissue sampling for possible future DNA testing in the 1990s, service members raised privacy objections that led the Department of Defense to strengthen safeguards against breaches of its DNA data banking system. After the Burlington Northern [Santa Fe](https://www.encyclopedia.com/places/united-states-and-canada/us-political-geography/santa-fe) Railroad conducted secret DNA testing on employees to determine genetic predisposition to carpal tunnel syndrome, the company entered into a settlement with the [Equal Employment Opportunity Commission](https://www.encyclopedia.com/social-sciences-and-law/political-science-and-government/us-government/equal-employment-opportunity) in May 2002, agreeing to pay $2.2 million to affected workers.

**DECISIONAL PRIVACY.** Individuals, families, and domestic partners typically define some decisions as personal decisions and certain conduct as intimate conduct. Under its fourth usage, privacy denotes autonomous choices about the personal and intimate matters that constitute private lives. Decisional privacy signifies the ability to make one's own decisions and to act on those decisions, free from governmental or other unwanted interference. Decisional privacy concerns in the health context relate to responsibility for important decisions about treatment, the termination of treatment, and the allocation of scarce medical resources. Legal and ethical disagreements about who has the "right to decide" or the "right to choose" sometimes have turned collaborating patients, physicians, nurses, hospitals, families, researchers, and lawmakers into competitors and litigants.

In the [United States](https://www.encyclopedia.com/places/united-states-and-canada/us-political-geography/united-states), conceptions of decisional privacy have come to dominate discussions of government regulation of abortion and the treatment of patients who are severely disabled, terminally ill, or in a persistent [vegetative state](https://www.encyclopedia.com/medicine/diseases-and-conditions/pathology/vegetative-state). In the context of so-called surrogate motherhood, privacy for infertile couples has meant the freedom to make legally enforceable agreements to procreate with the assistance of third parties. Gay men and lesbians invoke the ideal of privacy in their quest for the freedom to engage in consensual adult sexual relationships and marriage, free from the fear of criminal prosecution and legally sanctioned discrimination. Parents sometimes invoke "family privacy" to mean the freedom of heads of households to decide how those for whom they are responsible will be reared, educated, and medically assisted. Invocations to respect privacy accompany defenses of limited government and autonomous decision making respecting heterosexual sex, contraception, midwifery, women's prenatal conduct, use of experimental medical remedies, psychotropic drug therapy, organ sales and transplants, hunger striking, prostitution, and pornography.

**Theories about Privacy**

Theorists from disciplines that include philosophy, bioethics, and law have offered accounts of the meaning and value of privacy. Some of these accounts, though by no means all of them, have been prompted by a desire to clarify the assumptions and aims of health-related law and public policy.

**DEFINITIONS OF PRIVACY.** Contemporary theorists actively debate how precisely to define, value, and protect privacy (Cohen; Schoeman, 1992; Inness; Wacks; Allen, 1988). Although many acknowledge that privacy is used in distinguishable physical, informational, proprietary, and decisional senses, no single definition of privacy in any of its senses has gained universal acceptance. Nor has any theory of the value of privacy gained universal acceptance.

Scholars disagree about how to approach defining privacy (Allen, 1988). Some say privacy should be defined as a value or moral claim (Inness), others as a fact or a legal right (Gavison). Some say that definitions of privacy should prescribe ideal uses of the term (Gavison), others that definitions should describe actual usage (Allen, 1988). Debates over the definition of privacy may seem arcane. Yet the outcome of the debates bears importantly on the framing of ethical and legal issues raised by healthcare. For example, some theorists contend that the popular privacy arguments for abortion rights are unsound because they confuse privacy with liberty, autonomy, or freedom.

Proposed definitions of privacy range from the very expansive "being let alone," popularized by Louis Brandeis and Samuel Warren in an 1890 *Harvard Law Review* article, to Alan F. Westin's more specific "claim of individuals, groups or institutions to determine for themselves when, how, and to what extent information about them is communicated to others" (p. 7). Many definitions characterize privacy in its physical and informational senses as denoting conditions of restricted access to persons, their mental states, or information about them (Allen, 1988). According to Ruth Gavison, "[i]n perfect privacy no one has information about X, no one pays attention to X, and no one has physical access to X" (p. 428). So conceived, privacy functions as an umbrella concept, encompassing a family of concepts each of which denotes a form of limited access to others. There is disagreement about the composition of the privacy family's membership list. The list, however, arguably includes seclusion, solitude, anonymity, confidentiality, modesty, intimacy, reserve, and secrecy.

The debate over the relationship between the concepts of privacy and secrecy exemplifies the bewildering extent of disagreement about how to define privacy and related concepts. Although some scholars view secrecy as a form of privacy, others view privacy as a form of secrecy (Friedrich). Still others view them as distinct concepts. In a 1984 book titled *Secrets,* Sissela Bok argued that privacy and secrecy are wholly distinct concepts—the former referring to limited physical and information access, the latter to intentional concealment of information.

A number of definitions of privacy instead emphasize control, whether control over information or control over avenues of observation and physical contact (Fried; Westin). In the media-saturated and bureaucracy-dependent society of the [United States](https://www.encyclopedia.com/places/united-states-and-canada/us-political-geography/united-states), it is perhaps unsurprising that one scholar has suggested that privacy involves the possession of undocumented information (Parent, 1983a, 1983b). Other legal and moral theorists stress privacy as a social practice with normative functions (Inness). Jeffrey H. Reiman links privacy to the formation of individuality and personhood: "Privacy is a social ritual by means of which an individual's moral title to his own existence is conferred" (p. 39).

**THE DECISIONAL PRIVACY CONTROVERSY.** Perhaps the greatest source of definitional disagreement surrounding the concept of privacy has related to the decisional usage of privacy. Decisional privacy has been defined as control over intimate aspects of personal identity. In the United States, aspects of the human body, sex, reproduction, marriage, and family are generally considered as numbering among the intimacies of personal identity. The U.S. Supreme Court popularized the decisional usage of privacy in the 1960s, 1970s, and 1980s by characterizing laws restricting [birth control](https://www.encyclopedia.com/medicine/divisions-diagnostics-and-procedures/medicine/birth-control), abortion, end-of-life medical decision making, marriage, and parental authority as burdening the right to privacy. Decisional privacy rights in the law presuppose a private sphere of conduct immune from state or federal regulation. Some scholars emphasize the ideal of privacy as the ideal of limited government (Rubenfeld).

Many theorists insist that privacy in the decisional sense is not properly understood as a sense of privacy at all (Gavison; Parent, 1983; McCloskey; Ely). They raise several arguments. First, they argue, as an aspect of liberty, freedom, or autonomy, decisional privacy stands apart from paradigmatic forms of privacy, such as seclusion, solitude, and anonymity. Second, if one speaks of "decisional" privacy, one loses the ability to treat privacy and liberty as distinct concepts. Confused, ambiguous uses of the concept of privacy in the U.S. Supreme Court's first contraception and abortion cases helped to raise this widespread objection.

Defenders of the decisional usage of the term *privacy* counter that decisional privacy is worthy of the name (DeCew, 1987). They emphasize that although decisional privacy denotes aspects of liberty, freedom, and autonomy, it denotes aspects of these that pertain to deeply felt conceptions of a private life beyond legitimate social involvement. Controversial or not, using "privacy" to denote a domain outside of legitimate social concern has become an entrenched practice in the United States.

**THE PUBLIC AND THE PRIVATE IN POLITICAL THOUGHT.** Linkage with the Greco-Roman heritage of Western law and political theory may provide a degree of historic and etymological validity to the controversial practice of referring to freedom from interference with personal life as "privacy." The decisional usage of privacy has origins in classical antiquity's distinction between private and public spheres.

The Greeks distinguished the "public" sphere of the polis, or city-state, from the "private" sphere of the *oikos,* or household. The Romans similarly distinguished *res publicae,* concerns of the community, from *res privatae,* concerns of individuals and families. The ancients celebrated the public sphere as the sphere of political freedom for citizens. The public realm was the sector in which select men—free men with property whose economic virtue had earned them citizenship and the right to participate in collective governance—could truly flourish. By contrast, the private realm was the sector of mundane economic and biologic necessity. Wives, children, and slaves populated the private economic sphere, living as subordinates and ancillaries to autonomous male caretakers.

The post-Enlightenment Western liberal tradition inherited the premise that social life ought to be organized into public and private spheres (Arendt; Habermas). It also inherited the premise that the private sphere is properly constituted by the home, the family, and intimate association. Nevertheless, whereas ancient thought tolerated the private and celebrated the public, modern liberal thought often reflects an opposing tendency: It tolerates the public as pervasive and necessary for collective welfare but celebrates the private as an essential expression of personal identity, freedom, and responsibility.

The political concept of a limited, tolerant government—elaborated by the English philosopher [John Locke](https://www.encyclopedia.com/people/philosophy-and-religion/philosophy-biographies/john-locke) (1632–1704) and [Thomas Jefferson](https://www.encyclopedia.com/people/history/us-history-biographies/thomas-jefferson) as a requirement of [natural rights](https://www.encyclopedia.com/social-sciences-and-law/political-science-and-government/political-science-terms-and-concepts-46), and by the nineteenth-century English philosopher and economist [John Stuart Mill](https://www.encyclopedia.com/people/philosophy-and-religion/philosophy-biographies/john-stuart-mill) and the eighteenth-century Scottish economist [Adam Smith](https://www.encyclopedia.com/people/social-sciences-and-law/economics-biographies/adam-smith) as a requirement of utility—entails a nongovernmental, private sphere of autonomous individuals, families, and voluntary associations. Mill emphasized the importance of government tolerance, arguing that government is not well situated to assess the utility of "self-regarding" acts that potentially harm only the actors themselves. Self-regarding conduct "neither violates any specific duty to the public, nor occasions any perceptible hurt to any assignable individual except himself" (Mill, p. 80). It is, in other words, conduct that is restricted to an individual's own body and property and that may offend others but imposes no risk of significant harm on others. The contractarian political tradition of American democratic liberalism requires tolerance for religious minorities, political dissenters, and unpopular lifestyles. The ideal of tolerance is arguably the ultimate foundation of the case for sexual privacy for homosexuals and women seeking abortions (Richards).

The ideal of a private sphere free of government and other outside interference has currency, despite the reality that in the United States and other Western democracies, virtually every aspect of nominally private life is a focus of direct or indirect government regulation (Cohen). Marriage is considered a private relationship, yet governments require licenses and medical tests, impose age limits, and prohibit polygamous, incestuous, and same-sex marriages. Procreation and child rearing are considered private, but government child-abuse and neglect laws regulate, if at times inadequately, how parents, and possibly even pregnant women, must exercise their responsibilities. The ideal of a private sphere can be no more than an ideal of the ability of ordinary citizens to make choices that are relatively free of the most direct forms of governmental interference and constraint.

The worthiness of this ideal has been called into question in the United States, where problems of domestic and other private sector violence suggest a need for more rather than less involvement in the traditionally "private" spheres (Allen, 2003; Morris; MacKinnon). In addition, the ideal of a private sphere has been the ideal of a sphere of negative as opposed to positive freedom. The right to privacy in the context of contraception and abortion has meant a negative right against government decision making respecting procreation, not a positive right to governmental programs designed to make contraception and abortion services available to those who cannot afford to pay. Critics blame the emphasis on privacy and negative freedom for the failure of legal efforts to secure government funding of abortions for women who are poor.

**ETHICAL VALUES.** Physical and informational privacy practices serve to limit observation and disclosure deemed inimical to well-being. Psychologists have long emphasized the unhealthful effects of depriving individuals of opportunities for socially defined modes of privacy (Schneider). Many philosophers maintain that respecting physical, informational, and decisional privacy is paramount for respect for human dignity and personhood, moral autonomy, and workable community life (Schoeman, 1992; Allen, 1988; Kupfer; DeCew, 1986; Feinberg; Benn). Lawyers view the moral value of privacy as the basis of moral rights deserving legal protection (Greenawalt; Fried; Westin).

Scholarly disagreement about how best to characterize the ethical value of privacy is fundamental (Inness). One axis of disagreement concerns whether privacy denotes a value or a state of affairs. A second axis of disagreement concerns whether privacy, presumed to denote a state of affairs, refers to a state of affairs with necessary moral legitimacy or merely contingent moral legitimacy. A third axis of disagreement concerns whether the value of privacy, presumed to denote a state of affairs with only contingent moral legitimacy, should be measured against relevant consequentialist criteria, such as promoting aggregate happiness or efficiency; or deontological criteria, such as respect for personhood, personal identity, or humanity.

From the consequentialist perspective, privacy has value to the extent that it is useful in promoting, for example, aggregate happiness or the diverse interests of individuals, groups, or government. In this vein, scholars commonly argue that privacy has value because it functions to create or enhance human personhood in ways that promote liberal social and political institutions. Privacy practices promote individuality and the formation of self-concept presupposed by democratic self-government. Some accounts stress the utilitarian value to society of restraining government power in the spheres of what [John Stuart Mill](https://www.encyclopedia.com/people/philosophy-and-religion/philosophy-biographies/john-stuart-mill) called "self-regarding" actions.

Scholars also argue that privacy has instrumental value relative to its role in creating and enhancing relationships. The traditional argument is that only in isolation from others can desirable forms of intimacy and friendship flourish; only if individuals and families can seclude themselves from others can the potentially stifling and emotionally explosive social demands of group life be abated. In reply, it is argued that privacy practices have facilitated both the mistreatment of women and children and the disregard for the ideal of aggregate as opposed to individual responsibility. The ethical challenge posed by these criticisms is to describe social arrangements that vigorously protect states of physical and informational privacy in the name of individuality, creativity, family, and free association, but that avoid the subordination and alienation often associated with modern Western liberal societies.

Scholars sometimes explain what they regard as the value of privacy by reference to the importance of personhood and personal dignity to individuals. These arguments draw connections between limited physical and informational access and/or the ability to make important decisions for oneself and the very idea of rational moral autonomy. In his contribution to the 1971 book, *Privacy,* Stanley I. Benn argued, for example, that the principle of respect for persons provides a moral reason for not interfering with personal privacy. David A. J. Richards, in his 1986 book, *Toleration and the Constitution,* argued, by appeal to the "[social contract](https://www.encyclopedia.com/philosophy-and-religion/philosophy/philosophy-terms-and-concepts/social-contract)" metaphor, for legal privacy protections, stressing the fundamental value of government toleration of the choices individuals make for themselves pertaining to procreation, sexuality, and religion.

**Privacy in the United States**

The United States has a wealth of state and federal law protecting privacy. Recent federal law has increased legal safeguards for health information privacy at a time when Americans are increasingly open about formerly sensitive health matters.

***Patients' privacy rights.*** One of the most important areas of health law is the broad field of patients' rights. Discussions of patients' rights include the physical, informational, and decisional privacy rights recognized under tort, constitutional, and statutory law. A Patients' [Bill of Rights](https://www.encyclopedia.com/history/united-states-and-canada/us-history/bill-rights) that would include privacy protections emerged as a policy initiative during the presidency of George W. Bush.

The oldest American legal case decided by reference to rights of privacy, *DeMay v. Roberts* (1881), vindicated interests in physical privacy and modesty. A Michigan husband and wife successfully sued a physician who permitted an "unprofessional young, unmarried man" to enter their home and help deliver their baby. A century later a married couple in Maine brought *Knight v. Penobscot Bay Medical Center* (1980), a similar, though unsuccessful, lawsuit claiming that a hospital violated the couple's privacy by permitting a layperson, the spouse of a nurse, to observe delivery of their child through a glass partition from a distance of 12 feet. The issue of whether women should be able to choose who is present at the birth of their children—including whether delivery is undertaken with the aid of a midwife, nurse practitioner, or physician—is clearly both a physical and a decisional privacy issue.

All patients generally may share the obstetrical patient's sense that adequate privacy is lacking in hospitals where well-intentioned medical, administrative, and support staff move freely in and out of (even nominally "private") inpatient wards. The feeling that one's privacy has been invaded may be especially acute in busy, crowded public hospitals serving low-income patients or in any hospital where groups of several physicians, interns, and medical students simultaneously conduct physical examinations and discussions at one's bedside. Some men and women report feeling their privacy invaded by having to share a room in an intensive-care unit with a person of the opposite sex. The law is unclear about the extent to which medical resources or the general written consent to treatment patients give upon admission to hospitals eliminates legitimate expectations of physical and informational privacy. Specific waivers of legal privacy claims may give patients clear notice of the privacy losses associated with treatment in teaching and research hospitals, but arguably they do not eliminate hospitals' ethical obligations to respect privacy to the extent possible.

Moral outrage over the discovery that healthcare providers have recorded, filmed, or photographed a patient for scholarly or research purposes occasionally results in litigation. Respect for privacy would appear to dictate obtaining prior consent to the publication of graphic images of a person, particularly if the person is identifiable in an image or is named in connection with its publication.

The legal importance of obtaining prior [informed consent](https://www.encyclopedia.com/medicine/divisions-diagnostics-and-procedures/medicine/informed-consent) was underscored by the holding of the California court in a highly publicized case, *Moore v. Regents of*[*University of California*](https://www.encyclopedia.com/social-sciences-and-law/education/colleges-us/university-california) (1990). John Moore brought a multimillion-dollar lawsuit when he discovered that [University of California](https://www.encyclopedia.com/social-sciences-and-law/education/colleges-us/university-california) medical researchers who treated him for hairy cell leukemia had failed to disclose that "certain blood products and blood components were of great value in a number of commercial and scientific efforts." Moore's right to privacy claims were based on the notion that exploitation of his blood for commercial purposes was a highly offensive appropriation of a person's name, likeness, or identity compensable as an invasion of privacy under state tort law. According to the California court, a patient has a right to know the medical purpose of treatment and the treating physician's personal economic stake; otherwise treatment is battery, presumably no better than sterilizing a fertile woman or performing a cesarean section on a cancer patient without her consent.

As noted earlier, abortion, physician-assisted suicide, and the right to die are approached in the United States as patient privacy issues. Opponents of laws prohibiting abortions say that state and federal regulations should not prevent women from acting on their own decisions about whether to terminate pregnancy through medical abortion. On the other hand, it is also argued on privacy grounds that women should not be forced or counseled to abort for any reason, including where they are seropositive for the virus that causes AIDS. "Privacy" can signify freedom to choose the circumstances of death for oneself, a family member, or an intimate friend. It means the absence of criminal laws and bureaucratic procedures that constrain the choice to accelerate the death of a person who is terminally ill or to refuse artificial nutrition and hydration to preserve life in a person in a persistent [vegetative state](https://www.encyclopedia.com/medicine/diseases-and-conditions/pathology/vegetative-state). The right to privacy may also prove to be the ethical refuge of supporters of physician-assisted suicide of nonterminally ill, fully competent adults. In *Vacco v. Quill* (1996) and [*Washington v. Glucksberg*](https://www.encyclopedia.com/social-sciences-and-law/law/court-cases/washington-v-glucksberg) (1996), however, the U.S. Supreme Court ruled that states may outlaw physician-assisted suicide.

The privacy implications of nonvoluntary and routine AIDS testing of obstetrical patients, surgical patients, and newborns have been of great interest to public authorities and private healthcare providers for two reasons. First, nonconsensual testing is a prima facie denial of decisional privacy or autonomy. Some individuals prefer not to be tested and forced to confront the specter of terminal illness. And while this precise concern has never applied to newborns, newborn testing can reveal the HIV status of birth mothers. Second, where medical or insurance providers breach the confidentiality of an HIV- or AIDS-infected person, far-ranging implications for private lives and employment can follow because of prejudice and discrimination. In this context, policy analysts often assert that the individual interest in privacy is outweighed by societal interests, including the societal interest in controlling the spread of deadly disease through inappropriate handling of contaminated blood and other tissues. But societal interests do not always outweigh individual privacy rights.

The federal courts have upheld the mandatory AIDS-testing policies of the U.S. military and the nation's prisons. In *Glover v. Eastern Nebraska Community Office of Retardation* (1989), however, a federal court struck down a state requirement that all persons working closely with mentally retarded clients disclose their HIV and hepatitis B status and undergo periodic HIV and hepatitis B blood testing. Against the argument that persons working in highly regulated state agencies have lower expectations of privacy, the court stressed that constitutional values do not permit mandatory testing where the risk of disease transmission is extremely low. A similar weighing of the costs of testing against its benefits in view of the low risk of transmission may explain government reluctance to mandate AIDS testing for all dentists, physicians, and other healthcare providers who come in close contact with patients.

**Conclusion**

Privacy is likely to have an important role in bioethical discussions for some time. The English political philosopher James Fitzjames Stephen wrote in 1873 that "conduct which can be described as indecent is always in one way or another a violation of privacy" (p. 160). These words capture a truth about the broad usage the term *privacy* enjoys in the health field. Patients and those who care about them consider a diverse spectrum of "indecencies," ranging from maltreatment and breach of confidentiality to interference with decision making, as "invasions of privacy." Accordingly, the ethics, law, and politics of privacy have made what may be an indelible mark on the future of healthcare and health research.

Question 3 : concept of bioentrepreneurship?

**Concept of Entrepreneurship**:

The word “**entrepreneur**” originates from a thirteenth-century French verb, entreprendre, meaning “to do something” or “to undertake.” By the sixteenth century, the noun form, **entrepreneur**, was being used to refer to someone who undertakes a business venture.

The process of creation is called “**entrepreneurship**”. **Entrepreneurship** is a process of actions of an **entrepreneur** who is a person always in search of something new and exploits such ideas into gainful opportunities by accepting the risk and uncertainty with the enterprise.

Best definition of entrepreneurship

## Here's Stevenson's definition: Entrepreneurship is the pursuit of opportunity beyond resources controlled. ... Merriam-Webster gives a definition that's closer to what most of us would probably offer the English learner: an entrepreneur is “a person who starts a business and is willing to risk loss in order to make money.” Why Bioentrepreneurship?

Since the dawn of civilization, humans have been using products based on biotechnology. Today, these products, mainly based on our scientific research, are part of our daily life.

The biotech field leads to real-outcomes that allow the production of advanced technologies and products. Also, help to preserve the environment, encounter diseases, new biomedical devices, eliminate hungry, bio-fabric and biofuel production and more.

* A researcher usually starts a business based on biotech. That’s why a bio-entrepreneur has a lot of data, and more knowledge about its product makes it easier to identify and solve problems.
* A scientist develops an idea, invent something and then share it with the world, a for-profit in return. In this way, not only the world and society getting benefit from that invention. But also, the inventor itself gets a reward for his/her hard work.
* It encompasses the realization of ideas and concepts that arise from biology and other science fields.

Also, further implementing them into prospective business plans and startups. That was the reason behind the creation of bio entrepreneurship.

**Four types of enterprenurship**

It turns out that there are **four** distinct **types of entrepreneurial** organizations; small businesses, scalable startups, large companies and social **entrepreneurs**.

**7 Characteristics of Successful Entrepreneurs**

* Self-Motivation. One of the most important traits of entrepreneurs is self-motivation. ...
* Understand What You Offer. As an entrepreneur, you need to know what you offer, and how it fits into the market. ...
* Take Risks. ...
* Know How to Network. ...
* Basic Money Management Skills and Knowledge. ...
* Flexibility. ...
* Passion

**.What are the five theories of entrepreneurship?**

These are: (1) Economic **entrepreneurship theory**, (2) Psychological **entrepreneurship theory** (3) Sociological **entrepreneurship theory**, (4) Anthropological **entrepreneurship theory** (5) Opportunity-Based **entrepreneurship theory**, and (6) Resource-Based **entrepreneurship theory**

**10 Qualities of a Successful Entrepreneur**

* Disciplined. These individuals are focused on making their businesses work, and eliminate any hindrances or distractions to their goals. ...
* Confidence. ...
* Open Minded. ...
* Self Starter. ...
* Competitive. ...
* Creativity. ...
* Determination. ...
* Strong people skills.
* **Entrepreneurship vs Bioentrepreneurship**
* Certainly, there are similarities between bio-entrepreneurs and entrepreneurs like both must have a fabulous idea to start and to raise investment. Also, marketing their products and managing their startup.
* However, there are also some differences between the two;

|  |  |
| --- | --- |
| **ENTREPRENEURSHIP** | **BIOENTREPRENEURSHIP** |
| The process of launching a new business based on a great idea. | Starting a business based on an idea or invention from the various fields of science, like biotechnology, etc. |
| No such prior restriction and regulation | Strict regulation – as the biotech industry is the highest strictly regulated sector in business. |
| For normal startups, it takes less time for the development of products — for example, IT-based startups or online-based startups. | However, biotech-based startups take more time for the development of products, for example making vaccines or drugs or antibodies, etc. |
| In normal startups, you do not much need to worry about ethical committees. | Nevertheless, if you are concerned with biology-based products, then you need to get approval from ethical committees such as the FDA in the US. |
| A normal startup can start from minimal capital | Required huge investment – needs millions of dollars to turn your idea into reality (products) |
| Not that much risk | Also, the hurdle for bio-entrepreneurs is the high-risk that is scientific uncertainty. |

* Even though from the above differences, it may seem that starting a bio-based business may not be a wise idea. But if you think of the benefit, it can do for the world, that is far greater.Imagine the production of vaccines against some dangerous diseases, i.e. Coronavirus pandemic in 2020. How much can a bio-entrepreneur help the world? Of course, the returned capital is also in massive amounts.