

Patient Safety: The Ethical Imperative

The patient safety imperative began with the landmark report “To Err is Human” (Kohn, Corrigan, & Donaldson, 2000), which shocked the public by revealing that as many as 98,000 people die annually as a result of medical errors. Other research followed that supported the seriousness of the problem (Blendon et al., 2002; Healey, Shackford, Osler, Rogers, & Burns, 2002; Starfield, 2000).

A 3-year study (Cook, Hoas, Guttmanova, & Joyner, 2004) conducted in 29 small, rural hospitals in nine western states found that most errors fall within the sphere of nursing practice. Physicians, administrators, and nurses themselves tended to see patient safety as chiefly a nursing responsibility. However, nurses were not seen as members of the decision-making team that could remedy the problem.

Nurses have the ethical obligation to prevent and manage medical errors. Ethical theories for justification of stance are provided along with suggestions for disclosing errors to patients.

Systems Approach vs. Individual Blame

Systems theory holds that individuals are put in position to make mistakes by faulty design in the processes (Leape, 2005). It also suggests that individuals should not be punished for errors. A strong case could be made for holding managers and executives just as responsible for errors in health care as the frontline clinicians (Sharpe, 2003). They have significant control over decision making that affects patient welfare, and they are responsible for creating the vision of a culture of safety. In a culture of safety, misconduct is not tolerated. Misconduct is a deliberate violation of rules or policies (for example, not checking a restrained patient at least every 30 minutes). Disruptive physician behavior is deemed misconduct because of its caustic effect on the willingness of nurses to speak up (Rosenstein & O’Daniel, 2005).

The systems approach, however, does not relieve the individual nurse of responsibility. When the nurse makes an error, he or she has a responsibility to report the error, participate in investigating the causal systems failures, and reveal the error to the primary physician and the patient. Thus the sys-

tems approach actually empowers the nurse to contribute to systems improvement (Leape, 2005).

Errors in Nursing

The Institute of Medicine (IOM) defined error as “the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim” (Kohn et al., 2000, p. 28). This could be a wrong decision leading to an act of *omission* (for example, not changing dressing as ordered) or *commission* (action) (for example, misuse of equipment). However, the vast majority of nursing errors related to medication administration involve some deviation from the “five rights” (right patient, medication, dosage, route, time) (Kelley, 2002). These errors in nursing care are different from adverse outcomes, such as a properly placed but infiltrated IV.

Nurses report that the majority of errors are caused by job overload, indicating the likelihood that nurse staffing plays a major role in preventing errors (American Nurses Association [ANA], 2000). The fatigue from this overload affects critical thinking and may cause nurses to take shortcuts in an effort to complete tasks. The connection between the number and mix of competent nurses also must be considered in light of patient census and acuity.

Code of Ethics for Nurses: Clear Support for Patient Safety?

Though the ANA *Code of Ethics for Nurses with Interpretative Statements* (the *Code*) does not identify specifically the duty of the nurse to report errors, multiple statements undoubtedly lead to the nurse’s moral obligation to report and disclose errors (ANA, 2001). Specifically, provision three in the *Code* states “the nurse promotes, advocates for and strives to protect the health, safety and rights of the patient” (p. 12). As a patient advocate, the nurse must speak to the appropriate person of higher authority when incompetent, unethical, illegal, or impaired practice is noted in any health care professional. The *Code* expresses the need for an effective reporting system, which includes support and protection for the nurse.

In provision six of the *Code*, the nurse is informed of his or her responsibility for creating a moral environment. For example, “acquiescing and accepting unsafe or inappropriate practices...is equivalent to condoning unsafe practice” (ANA,

Vicki D. Lachman, PhD, MBE, APRN, is a Clinical Associate Professor, Drexel University, Philadelphia, PA.

2001, p. 21). The convention of silence must be broken if patient safety is to be seen as an ethical imperative.

Strategies to Comply with Ethical Imperative

Nurses have a moral obligation to their patients to do everything they logically can to make sure patients are safe. First, do no harm. Simple practices such as handwashing are known to reduce the incidence of nosocomial infections (Gerberding, 2002), but compliance is alarmingly low for nurses (Larson, Aiello, & Cimiotti, 2004).

What are strategies to comply with the ethical imperative for patient safety?

1. *Implement and follow safe practice.* If the data are clear, the only morally valid action is 100% compliance. It is thus imperative to implement and follow the safe practices outlined by the National Quality Forum (2003). However, the Forum's list of 30 practices is not executed in all hospitals; most have only put into practice those required by the Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations [JCAHO], 2001).
2. *Create a reporting system that honors nurses' confidentiality.* Nurses have an ethical obligation not only to today's patients, but also to future patients. They need to learn from errors and make the necessary changes to prevent a comparable occurrence from happening again. This can best be done in a "no blame" culture where near misses are mined to prevent hazards to future patients.
3. *Disclose the error to the patient.* The injured patient has a right to know what happened (Leape, 2005). However, one study (Cook et al., 2004) found only 64% of health care providers would disclose an error to the affected patient, even when there was overwhelming agreement among participants (97%) that an error had occurred. Disclosing errors is consistent with the nurse's position as a patient advocate. Such disclosure supports patient autonomy, and helps ensure that the patient is fully informed and able to make appropriate decisions (Kelley, 2002). The IOM recommends voluntary, confidential reporting systems within all health care institutions (Kohn et al., 2000).

Joint Commission (2007) standard RI 2.90 requires that "patients and, when appropriate, their families are informed about the outcomes of care, treatment, and services that have been provided, including unanticipated outcomes" (p. 147). The standards are silent on scope and content of error disclosure (Banja, 2003). However, a qualitative study that included 45 nurses yielded six elements of disclosure that match what patients desire (Fein et al., 2007, p. 757).

- *Admission.* Did the discloser admit to the patient that there was an error?
- *Discuss the event.* Was the occurrence of the event containing the error clearly discussed with the patient?
- *Link to proximate effect.* Did the discloser com-

municate to the patient the link between the error and its proximate effect in a way the patient could understand?

- *Proximate effect.* Was the effect of the error discussed with the patient?
- *Link to harm.* If there was harm from the error, was the link between the error and harm sustained by the patient communicated in comprehensible fashion?
- *Harm.* If there was harm from the error, was there communication concerning the harm?

The following example is a full disclosure using all six elements. "Because of an error on my part, you got your insulin when you should not have. I apologize for that. It caused you to have very low blood sugar, which caused you to have a seizure. The seizure caused you to fall out of bed and that is when you broke your hip."

If the hospital also removes from the patient's bill any costs associated with the error, then the nurse can add this information to the apology.

Currently, the system of liability for medical harms makes meeting this responsibility for disclosure possible only through courage. The present system discourages this level of honesty and openness between health care professionals and patients. Viewed from the perspective of utility ("greatest good for the greatest number"), the tort process is ineffective (Banja, 2003; Fein et al., 2007).

4. *Report nurses who commit unethical, unlawful, or incompetent acts to the appropriate person.*

Most organizations do not have a good system to identify nurses who have substance abuse or mental illness. Nurses with physical illnesses, such as diabetes, also may have impaired performance. This breakdown in ensuring competent, safe practice of all nurses is a major failing of the profession. My experience, after more than 20 years in the field of substance abuse in nursing, is that nurses need better systems of identification, support, and re-entry to fulfill their ethical responsibility to care for the public and assist their colleagues.

Ethical Theories Addressing Patient Safety

Most theorists who provide the basis of current philosophical considerations did not live in a time of medical litigation. Aristotle's *Nicomachean Ethics* (1954) centered on the moral virtues of courage, temperance, prudence, and justice. Disclosing a medical error, especially when the nurse feels personally responsible, requires significant moral courage. The nurse needs to face and honestly accept mistakes. Justice involves two human beings whose interests must be considered, according to societal mores or laws, if there is to be a just outcome (Mavroudis, Mavroudis, Naunheim, & Sade, 2005). The nurse thus must treat the patient in the same manner that he or she would want to be treated.

Humility is also a virtue that is vital in dealing with errors. By being humble, an individual has the capacity for openness to admit his or her fallibility. Humility leads to the recognition of personal limitations. It is defined as an individual's awareness of and state of ease with his or her imperfections

(Crigger, 2004). By recognizing personal fallibility, a person has a more receptive attitude toward others as well as more willingness to forgive self and others. Therefore, the ethical response to making a mistake begins with being humble enough to disclose the error honestly.

This response is supported by Kant's moral theory of the categorical imperative against lying (Kant, 1996), which asks us to do only the behavior that we believe should be universal law. According to Kant, anything short of full disclosure of the error would deprive the patient of his moral dignity. Trust between the patient and the nurse requires this open communication. Nurses are duty-bound to avoid intentional deception (for example, explaining the injury with other plausible causes).

The principal approach to ethics is a modern theory using four ethical principles of autonomy, beneficence, nonmaleficence, and justice.

The school of Utilitarianism focuses on maximizing the benefit and minimizing the harm ("the greatest good for the greatest number") (Kelley, 2002). The patient will benefit by having accurate medical information, but society will benefit as well. The goal of improving patient safety will only be accomplished if system problems that create errors are examined continuously.

The principal approach to ethics is a modern theory using four ethical principles of autonomy, beneficence, nonmaleficence, and justice (Beauchamp & Childress, 2001). Respect for autonomy is a crucial accountability of all nurses as patient advocates. Without disclosure of error, the patient lacks the necessary information for self-determination. Beneficence, the moral obligation to prevent harm, is endangered if errors are not reported. The opportunity to prevent other nurses from making the same mistake is lost. Nonmaleficence (to do no harm) is the principle violated in all patient errors.

Justice could be obtained in a no-fault liability or mediation process; however, traditional tort liability is the worst way of achieving justice and safety improvement (Sharpe, 2003). For voluntary reporting to be workable, providers need to know the information will not be used against them in a malpractice case. This guarantee of peer protection is justified ethically by the principle of utility (for example, greater amount of data to examine harmful errors).

Ethics of care theory focuses on the importance of maintaining relationship. The most important expression of care is in the actions taken. The commitment is to maintain a relationship that honors the particular needs of the patient. This is not possible without mutual trust and honesty. Therefore, error reporting and disclosure must be done in a way that best serves the individual patient.

Conclusion

While nurses are working to prevent mistakes, they also must offer apologies when they disclose mistakes and make amends when possible. Their *Code* (ANA, 2001) and multiple ethical theories support these actions. An immense challenge lies before nurses, but they must meet this ethical imperative for their patients' sake. ■

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