Patient Safety and Ethics: A Conflict of Goods

Joal Hill, JD, MPH, PhD

Nurses often face ethical dilemmas when providing care to patients with cancer. Although “doing the right thing” may seem obvious in the decision-making process, nurses are frequently challenged with a conflict of doing good regarding patient safety and patient advocacy versus maintaining collegial relationships.

W

Working hard to update and maintain her skills is one of the things C.F. enjoys most about her job as an oncology surgical nurse. As part of a safety initiative at C.F.’s institution, a patient safety policy was implemented that includes a short presurgical checklist to verify characteristics such as patient identity and site of surgery. C.F.’s job involves completing the checklist with the surgeon and making sure filing is done properly. Institutional policy mandates use of the checklist prior to any procedure that requires anesthesia. Internal audits occur regularly to monitor compliance and to verify proper record keeping for external regulatory purposes.

Prior to a morning surgery, C.F. prepared the patient safety checklist in the usual manner but was rebuffed by Dr. T, a recently hired surgeon with whom C.F. had never worked. “We don’t need that,” he said, “I know what I’m doing.” C.F. gently but firmly informed Dr. T that completion of the checklist is mandated for all surgeries regardless of who performs a procedure, but he still refused. No one else in the room said anything. What should C.F. do?

Commentary

This scenario presents C.F. with a conflict of goods, which in itself defines the concept of an ethical dilemma. In other words, C.F. must choose among competing obligations, each of which constitutes a virtue of character or action among nurses. In this case, C.F. should prioritize and choose among the ethical precepts of advocating for patients with cancer generally (and this patient in particular), maintaining collegial relationships with other health professionals, and observing institutional and regulatory standards.

The ethics of patient safety have been well documented, particularly since publication of the Institute of Medicine’s (1999) influential report, To Err Is Human: Building a Safer Health System. The American Medical Association, the American Nurses Association (ANA), and other healthcare professional societies and journals emphasize that preventing harm to patients is both an individual and organizational ethical responsibility (Batcheller, Burkman, Armstrong, Chappell, & Carelock, 2004; Egan, 2004). In addition, the ANA (2006) specifically applied its Code of Ethics to Patient Safety in a position statement that addressed the ethical responsibility of nurses to prevent harm by considering their level of fatigue when asked to accept work assignments extending beyond the regularly scheduled work day or week. The same four code provisions identified in the 2006 document also apply to C.F.’s situation: the nurse’s primary commitment to the patient; the nurse as an advocate for patient rights, health, and safety; the individual obligation to provide optimal patient care; and the responsibility to establish and maintain quality care (ANA, 2001).

Provisions

Commitment to the patient: This provision, in particular, establishes the nurse’s primary obligation to the patient (ANA, 2006). In this case, an existing, identifiable patient is about to undergo surgery. This self-evident element of C.F.’s predicament would seem in and of itself to indicate C.F.’s course of action: Insist on completion of the checklist. Why would C.F. or any other nurse hesitate? At least two important factors should be taken into account. First, because no one present at this impasse has supported C.F. (an ethical breach on their part), the potential for delay in resolving this matter must be weighed against the possibility of harm to the patient resulting from that delay. It may be that this policy includes steps for reporting or resolving this situation in a timely fashion, such as calling an in-house rapid response number or documenting the refusal, proceeding with the intervention, and reporting the noncompliance immediately thereafter. When implementing new policy and practice, the steps that should be taken when a breach occurs should be considered by weighing the time required for corrective action against unintentional harm that may result to a patient as a consequence. In this case, ironically, it would undermine the intent of the checklist if the patient’s immediate health is compromised as a result of C.F. and Dr. T prolonging this disagreement. If that is the case, then the second best course of action is for C.F. to wait until
immediately after the procedure to continue her conversation with Dr. T or, if he is unwilling to speak with her, report his noncompliance in the proper manner. The second consideration that may cause hesitation involves C.F. finding herself in a situation where ethical professional action may result in personal hardship or loss. Although C.F.’s ethical and institutional mandate clearly points to the priority of ensuring patient safety, she must understandably acknowledge the possibility that Dr. T may report her for insubordination or, because he is in the wrong, he may engage in less formal ways of disrespecting, alienating, or otherwise punishing her for insisting on following this protocol. If this response is a possibility for C.F., although it should not prevent her from doing the right thing, it may cause her to think carefully about how to conduct herself following this event, including with whom she should and should not communicate verbally and in writing. This includes observing the proper reporting hierarchy and avoiding gossip.

Nurse advocacy: This provision describes the nurse as an advocate for the safety and rights of the patient (ANA, 2006). At first glance, this may seem redundant given the primary commitment to the patient emphasized in the previous provision. Here the code’s interpretative statements provide instruction: Whereas the previous provision emphasizes relational aspects of the nurse-patient encounter (such as competing interests and maintaining proper boundaries), the nurse advocacy provision addresses the nurse’s institutional commitment to patients by following regulatory and institutional standards and reporting questionable practice. In this regard, Dr. T’s refusal to complete the checklist is a medical error, as defined by the Institute of Medicine (1999): “The failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim” (p. 1). Although most errors are unintentional lapses, however serious, errors also include intentional refusals, however minor.

Optimal care: This provision emphasizes individual responsibility and accountability for nursing practice, the latter being defined as “answerable to oneself and others for one’s own actions” (ANA, 2006, p. 3). That captures a critical aspect of ethical reflection and growth: Behaving in such a way that one observes a rule so as not to be punished is one thing, but a more virtuous path is to behave in such a way that one can live with oneself whether or not one’s actions are culpable or even known. When faced with choices such as C.F.’s, ethical reflection requires a nurse to ask, “What kind of nurse do I want to be?” Although there may be a temporary cost to challenging Dr. T, digging deep into her professional and personal values should encourage C.F. that she is doing the right thing and that she is prepared to be accountable for her actions. Therefore, she should consider not just whether she will stand her ground with Dr. T, but how she will do so. Being correct in a given situation does not justify disrespectful words or behavior; responsibility and accountability entail self-control and appropriate conduct.

Quality care: This provision provides additional insight by addressing a nurse’s responsibility to build and support environments conducive to ethical practice. Here, the interpretive statements emphasize that “acquiescing and accepting unsafe or inappropriate practices” (ANA, 2006, p. 3) is tantamount to condoning such practices. By this standard, C.F. yielding to Dr. T’s refusal (and the failure of others present to speak up) cannot be viewed as morally neutral. Rather, such passivity would be interpreted as condoning the breach and willfully ignoring patient safety.

Having established that C.F.’s primary obligation is to the patient, analysis of the case study can be completed by considering the views of the patient. Rachaidai, Dierchxx de Casderle, DeBlaeser, and Gastmans (2009) reviewed international literature to learn how patients with cancer characterize a good nurse. Among the qualities particularly pertinent were nurses who relate to the patient as a person, nurses who keep promises, nurses who make few mistakes but apologize and take responsibility when mistakes are made, and nurses who do not just follow rules rigidly but apply their skills appropriately in each situation (Rchaidai et al., 2009). The parallel between these patient perceptions and the virtues inherent in the ANA (2001) Code of Ethics is striking. By considering the patient awaiting this surgery, reflecting on the fidelity to ethical standards inherent in her profession, being willing and prepared to take accountability for her actions, and by employing all of her creative and reasoning abilities in appealing to Dr. T, C.F. has an opportunity to not just follow rules, but to demonstrate why the rules exist and to serve those for whom they exist.

Core Commitments

From the facts of this case, fully discerning the motives or ethical awareness of C.F. or Dr. T is difficult. Perhaps C.F. is less the hero and Dr. T less the villain than presumed. Her insistence on completing the checklist may be more out of rote practice and hidebound stubbornness than virtue or ethical acuity. Dr. T may be a decent, skilled, but also overworked physician who is having an atypical day. And what of their colleagues who have chosen to do nothing? Regardless of their motives, the ethical commitment of every professional in this scenario is the same: Put patients first and do no harm. In the face of real-world constraints and pressures, the actual human beings who rely not only on the knowledge and skill of the profession of nursing, but also on its integrity, must not be forgotten. Although this matters for all patients, it may be particularly true for those who are vulnerable, such as the patient with cancer whose welfare and safety C.F. and Dr. T are obliged to protect.

References


