Ethics of everyday decision making

Gina Kearney and Sue Penque discuss the responsibility of staff to document care accurately. Using the example of checklists, they show how simple omissions can put patient safety at risk.

Abstract

Evidence suggests that checklists can prevent episodes of patient harm and they are increasingly being used in patient care to ensure that procedures are being carried out. However, checklists cannot do so alone and in some situations the checklist might indicate that an intervention has been undertaken when it has not. Healthcare providers, particularly nurses, must consider not only the increase in the use of checklists, but also the way in which they present a context for ethical decision making. This article examines the ethical dimensions of using checklists, played out in the context of a scenario, and suggests that failure to take ethics into account when considering checklists might perpetuate rather than prevent unsafe practices or errors. The article is set in a US context, but the issues are relevant to healthcare settings in any part of the world.

Keywords

Checklists, ethical decision making, patient safety

ESTIMATES OF the number of Americans who die annually from preventable medical errors are astonishingly high, with studies citing figures of between 44,000 and 98,000 (American Hospital Association 1999, Kohn et al 2000). As a result, US consumer and regulatory bodies have dedicated considerable human and financial resources to ameliorating the problem by setting standards to promote and ensure safety and to mitigate errors.

The US healthcare industry has, in addition, entered an era of transparency, with publicly reported quality and patient safety data, and is no longer reimbursed for costs associated with certain preventable or hospital-acquired conditions.

In the coming years, through provisions made by the Centers for Medicare and Medicaid Services (CMS) and the recently enacted Patient Protection and Affordable Care Act, US hospitals will be under pressure to address safety and quality issues. Reimbursement for hospital care will diminish and fines will be imposed for not meeting specified, predetermined quality indicators (Cromwell et al 2011).

A major movement to encourage institutions to shift towards a non-punitive and fair culture of safety and zero errors is gathering momentum. It is led by several national organisations that include the Committee on Quality of Health Care in America/institute of Medicine of the National Academies, the Institute for Healthcare Improvement and the US Department of Health and Human Services Agency for Healthcare Research and Quality.

Central to this movement is the incorporation of strategies developed in the aviation industry, which include using checklists to foster and ensure safe practice.

Numerous examples illustrate the success of checklists in preventing individual episodes of harm and even fatalities, such as the World Health Organization’s Surgical Safety Checklist (2009) and the Checklist Manifesto (Gawande 2009). However, healthcare providers, and nurses in particular, must be encouraged to look not only at how checklists are increasingly used in daily practice, but also how they present a subtle yet requisite context for ethical decision making. Failure to examine the ethical dimension of such routine activities may perpetuate rather than prevent unsafe practices or errors occurring.

Nursing documentation

Documentation is a significant component of nurses’ daily practice and serves as ‘one important mechanism used to evaluate care performance conducted by the caregiver serving as the centre of nursing activities’ (Cheevakasemsook et al 2006).
Care plans, pre-operative flow sheets, core measure documents and vital sign records are just some of the documents often laid out as checklists.

In the Checklist Manifesto (Gawande 2009), these documents are all considered as checklists or tools designed to ‘provide protection against failures’ by reminding practitioners and making explicit ‘minimum necessary steps’ that ‘offer the possibility of verification, but also instil a kind of discipline of higher performance’.

Nurses will be familiar with the mantra, ‘If it wasn’t documented, it wasn’t done’, which suggests that, in organisations where a fair culture of safety is promoted and checklists are used, unintentional errors are eliminated and that safe, high quality care is reliable and has optimal clinical outcomes.

However, it is questionable whether documentation tools such as checklists can guarantee patient safety and quality. With an emphasis and reliance on documentation that demands that ‘all boxes must be ticked’ to ensure complete care has been provided, the process can easily be reduced to completion of the checklist.

It is, therefore, important to consider the ethics of a situation in which interventions have been documented, but have not in fact been undertaken. The emphasis on prioritising completion of documentation could result in a problem that has not been considered before and generate an unintentional culture of unethical and unsafe practice in which leaders, managers and supervisors potentially become enablers or accomplices to nurses’ unethical decision-making behaviours.

Organisations that are intent on mitigating errors and rectifying problems through such a process might, in reality, be encouraging individuals to participate in unsafe and unethical behaviours. This view deserves consideration and examination from an ethical perspective.

Ethical frameworks
Magill and Prybil (2004) emphasise that ‘stewardship and integrity’ are vital to ensuring what they describe as ‘virtuous organisations’, through inspiring ethical standards of conduct and decision making in the workforce. They add that ethical overview is mandatory to ensure patient safety. When policies place utmost emphasis on documentation, it is vital that those in leadership positions give as much weight to taking an overview of the process as to the tools used to deliver effective care.

From a legal standpoint, when care has not been provided or ‘the box has not been ticked’ on a document, the error or mistake is one of ‘omission’, whereby the provider has not complied with or provided a service according to an established standard of practice (Crigger 2004). This type of error is easy to recognise since the blank space is obvious when a document is reviewed.

However, when a box has been ticked, indicating that care has been delivered, there is no guarantee that care was partially or completely given to the patient; this is termed ‘commission’, which, according to Crigger (2004), describes a situation in which the service or action – that is, completion of the documentation or checklist – is provided improperly.

Again, legally, the expectation and professional responsibility for documenting care is upheld, but whether or not the ethical and moral imperative was followed cannot be absolutely determined. The opportunity to reveal the truth of the situation might be lost. Although it is not reasonable to assume that all documentation can or will be verified on review, it is simply assumed that nurses will never falsify documents.

However, this does happen. For example, in the morning, nurses may choose to record the plan for the patient’s care in the documentation, but they may be unable to deliver that care as the day

Strategies to improve patient safety
The past few decades have seen greater emphasis on improving outcomes in relation to quality of patient care. In the US, the Institute of Medicine has published two reports prepared by the Committee on the Quality of Health Care in America project on the situation in America and how to improve quality of care.

The first report, To Err is Human (Kohn et al 2000), focused on concerns relating to medical errors and on improving quality of care and patient safety. The second, Crossing the Quality Chasm (IOM 2001), looked more broadly at how the healthcare delivery system can be designed to innovate and improve care, and identified strategies for making substantial improvements in care.

To Err is Human highlighted the cost of errors in terms of individual lives, public loss of confidence in health care, healthcare professionals’ loss of morale in not being able to provide the best possible care and the financial implications. The report concluded that most mistakes were preventable, and proposed a reduction in such errors over five years. In its recommendations to achieve this goal, the project stressed the need for a balance between regulatory and market-based initiatives and between the roles of professionals and organisations.

The follow-up report (IOM 2001) included of an extensive review of literature. It set out a comprehensive strategy and action plan to encourage innovation and improve the delivery of care, outlining key steps to achieve this goal.

The IOM project has called on the public, industry and healthcare professions and other stakeholders in health care, ‘to continually reduce the burden of illness, injury, and disability, and to improve the health and functioning of the people of the United States’. It says that ‘mistakes can best be prevented by designing the health system at all levels to make it safer – to make it harder for people to do something wrong and easier for them to do it right’.
Checklists can improve patient safety, but in isolation they cannot prevent harm or errors in health care.
From a consequentialist perspective, however, the potential for this to become widespread practice must be prevented.

According to Tenbrunsel and Messick (2004), when systems are assumed to be “error proof” environmental causes of unethical behavior can be overlooked. Reliance on an error-proof checklist to be completed by nurse X, who is responsible for many other tasks and checklists, and possibly has limited time to complete them, can create an environment of unrealistic or impractical expectations. This situation can enable nurse X to make an unethical choice simply out of frustration with the system. Further, if she believes the problem cannot be fixed, or if she can shift responsibility to another party, it becomes easier and possibly desirable to separate herself from the moral implications of her actions and the issues.

Finally, Tenbrunsel and Messick (2004) acknowledge that through the ‘constrained representation of our self’ people do not have the ability to truly and objectively perceive the world or to accurately and fully perceive how their behavior affects others. Nurse X sees only the justification for the choice she has made, and ignores any foreseeable effects of her actions. She might be attempting to be conscientious and get the tasks and related documentation completed before the end of her shift. However, in justifying this shortcut nurse X creates a potentially dangerous, harmful and unsafe situation for the patient.

For example, other members of the healthcare team might act on the assumption a particular element of care has been provided when it has not. Consequently, treatments might be viewed as ineffective, medications could be discontinued or changed, dosage might be increased and prognoses made under false circumstances. The ethical principle of non-maleficence, or to do no harm, is in jeopardy while the principle of beneficence, to provide a good or to benefit people, is violated (Grace 2009).

From the perspective of deontology – the branch of ethics that deals with duty, moral obligation and moral commitment – further ethical dilemmas can be revealed from this scenario. Acting as patients’ advocate and maintaining patients’ trust by observing professional responsibility and accountability are core nursing values that invoke ethical behaviors and actions.

Nurse X departs from this role and other motives take precedence. While patient care is and always should be the primary concern, the risk is also shared among nurse X’s co-workers and employers. To evaluate how this might be addressed, it is worth considering the following: ‘There are overlooked ethical challenges in the mundane, everyday routine activities of professional practice, and these have gone largely unexamined. Ethical behavior is not the display of one’s moral rectitude in times of crisis. It is the day-to-day expression of one’s commitment to other persons and the ways in which human beings relate to one another in their daily interactions’ (Levine 1977).

**Fostering ethical behaviours**

As greater emphasis is placed on structures and processes, including checklists, to enhance patient care and promote patient safety, knowledge of ethical behaviors and an understanding of moral principles should be used to develop a reasoned analysis.

The implications of workflow processes, actions and the design of workplaces or work systems should be considered carefully, and nurse leaders should realise that paper or electronic documentation forms or processes will not by themselves ensure patient safety and quality of care. While electronic health records tend to create checklists, the question of whether or not procedures or tests have actually been carried out remains. Of course, checklists can improve patient safety, but in isolation they cannot prevent harm or errors in health care.
Tenbrunsel and Messick (2004) say that ‘efforts designed to reduce unethical behavior are best directed on the sequence leading up to the unethical action’. This suggests that it is vital that leaders understand what individual nurses are experiencing as well as the factors that influence their decisions to act unethically.

Leaders are responsible for establishing environments that foster ethical behaviours, and creating healthy work environments through the establishment of a fair culture would help minimize or eliminate the conflict experienced by nurses who want to take the correct course of action but are fearful of retribution or blame by those in authority.

The standards of the American Association of Critical-Care Nurses (2005) for establishing and sustaining healthy work environments indicate that ‘inattention to work relationships creates obstacles that may become the root cause of medical errors...’ and state that ‘skilled communication supports the ethical obligation to seek resolution that preserves a nurse’s professional integrity while ensuring a patient’s safety and best interests’.

Creating a dialogue between nurses and leaders about ethical behaviour is vital. Nursing staff must understand and be able to discuss the ethical and moral nature, and implications of, their actions, as well as the routine activities that are considered mundane in everyday practice, in a safe environment. Nurse educators, managers and administrators are all responsible for supporting these discussions and implementing supportive processes.

Nurses must have a strong knowledge base and understanding of their regulatory body’s or professional association’s code of ethics. In the US, the American Nurses Association code of ethics (2001) contains provisions for ‘wholeness of character, preservation of integrity and influence of the environment on moral virtues, values and ethical obligations of the nurse’.

To advocate for patients as well as for nurses, creative thinking must be supported and encouraged to effectively envision and critically assess potential solutions. Even current solutions can be improved and regarded from different perspectives.

**Conclusion**

There is enormous pressure on all healthcare providers to document care on checklists, particularly when compliance and outcome data, as well as individual performance assessment data, are derived from such documentation and when this is publicly reported or determines reimbursement.

An empowered, ethical working environment and structure for nurses and nursing practice is necessary and attainable, and nurse leaders must not become complacent and allow competing demands and priorities to override purposeful, deliberative dialogue and debate. Leaders must also be able to recognise and avert the subtle, unintentional development of unsafe, unhealthy, and potentially unethical work environments.

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**References**

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