

Patient safety and ethical aspects: scoping review

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Abstract

The objective was to identify the ethical aspects present in the context of patient safety in health services. This was a scoping review on the following databases: Lilacs, Medline, Ibecs, BDNF, CINAHL, SciELO and Google Scholar in September 2019. Original research papers, experience report, theoretical studies, and editorials were included. The review comprised 32 studies published between 2004 and 2019. Seven categories emerged from the analysis: organizational and team factors; communication with patient; incident reporting; beneficence and non-maleficence; justice; autonomy and potential elements of ethics in patient safety. The results of this review may be useful to improve the sensitivity of healthcare professionals working in patient care about the ethical aspects that involve patient safety.

Keywords: Ethics. Bioethics. Patient safety. Medical Errors. Review.

Resumo

Segurança do paciente e aspectos éticos: revisão de escopo

O objetivo deste estudo foi identificar aspectos éticos relacionados à segurança do paciente em serviços de saúde. Para isso, realizou-se uma revisão de escopo nas bases SciELO, Lilacs, Ibecs, Medline, Bdnf, Cinahl e Google Acadêmico em setembro de 2019. Foram incluídos na amostra artigos originais, relatos de experiência, estudos teóricos e editoriais. A revisão abrangeu 32 estudos, publicados entre 2004 e 2019. Da análise do *corpus* resultaram sete categorias: fatores organizacionais e da equipe; comunicação com o paciente; comunicação de incidentes; beneficência e não maleficência; justiça; autonomia; e elementos potencializadores da ética na segurança do paciente. Acredita-se que os resultados desta revisão podem ser úteis para sensibilizar profissionais de saúde para aspectos éticos que envolvem a segurança do paciente.

Palavras-chave: Ética. Bioética. Segurança do paciente. Erros médicos. Revisão.

Resumen

Seguridad del paciente y aspectos éticos: revisión de alcance

El objetivo de este estudio es identificar aspectos éticos relacionados con la seguridad del paciente en los servicios de salud. Para ello, se realizó una revisión de alcance en las bases SciELO, Lilacs, Ibecs, Medline, Bdnf, Cinahl y Google Acadêmico en septiembre del 2019. Se incluyeron en la muestra artículos originales, relatos de experiencia, estudios teóricos y editoriales. La revisión incluyó 32 estudios publicados entre el 2004 y el 2019. Del análisis del *corpus* resultaron siete categorías: factores organizacionales y del equipo; comunicación con el paciente; comunicación de incidentes; beneficência e não maleficência; justiça; autonomía; y elementos potenciadores de la ética en la seguridad del paciente. Se considera que los resultados de esta revisión pueden resultar útiles para sensibilizar a los profesionales de la salud hacia los aspectos éticos que implican la seguridad del paciente.

Palabras clave: Ética. Bioética. Seguridad del paciente. Errores médicos. Revisión.

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Patient safety is an emergent issue worldwide, given the greater concern with respect for patient's dignity, quality of care, and health system stability¹. The magnitude of the problem – shown by the high number of incidents related to care with potential for transient and permanent damage, as well as individual and social costs – justifies the efforts in researching the topic¹.

Among the incidents and contributing factors to the occurrence of unintended adverse events during care are failures in drug treatment, diagnosis, and health services organization, incomplete clinical records, lack of staff training, and inadequate communication between professionals and patients². All these factors, when analyzed from an ethical perspective, require reflections both in the scope of personal and organizational commitment.

There is still a gap regarding the ethical aspects involved in patient safety. And the question is not an ethical one just out of respect for each patient; the problem is also clinical and sanitary, as it impacts the quality of services and sustainability of the health system. In this sense, considering that one of the principles of ethics is “above all, do no harm” (principle of non-maleficence), the issue of security becomes inexcusable³. Safety and efficiency are quality requirements of care⁴.

Professionals must protect their patients from harm by providing quality assistance. Safe and quality care, however, will only be guaranteed if professionals are aware of ethical issues. Thus, ethical aspects of safety should be systematically included in health services, enabling the development of best practices. In this context, this study aims to connect ethics and patient safety from a scoping review. The results are discussed based on the theoretical framework of the ethics of responsibility by Max Weber⁵ and Hans Jonas⁶.

Max Weber⁵ analyzes the transition from a policy understood as an independent liberal action, defined by individual activities, to a policy perceived as an exercise dependent on the organizational structures of governments and parties, comprising a state bureaucracy that determines the action. If in the first case ethics refers to the politician's subjective convictions, in the second, it is guided by the results of

political actions. While individual's convictions are irrelevant, their responsibility regarding the collective consequences of their actions is not. For this reason, Weber argues that the ethics of responsibility is a more adequate model for the ethics of current political actions, and the same can be said of the ethical exercise of health and care actions concerning patient safety.

Hans Jonas, in turn, develops an ethics of responsibility for technological times⁶. When proposing a new model, Jonas points out three elements to be considered at a time when technology underlies the shaping of society. According to the author, to define how we should act, we must refer to the negative consequences of actions, with a higher concern regarding the effects than the causes. From this premise, we have that the future becomes a central reference for understanding how to act ethically – not so much the past and the present, as before. Finally, the third element for an ethics of responsibility is the need for a continuous criticism of utopia as a definer of the future, always bearing in mind the negative, realistic results of actions, in a kind of heuristic of fear⁶. Jonas defines “responsibility” as a non-reciprocal action that includes trust, and, in that sense, it involves an unbalanced relationship. Thus, fragile humans, who have their well-being, interest, and destiny put under the care of others, have defined obligations towards those “responsible” for them, and to whom they become an object of control.

Based on these theoretical frameworks, this study aims to identify and discuss ethical aspects of patient safety in the context of health services.

Method

This article presents results of a systematized scoping review⁷ according to Levac, Colquhoun, and O'Brien⁸, which establish the following steps: 1) identification of the research question; 2) identification of relevant studies; 3) selection of studies; 4) data extraction; and 5) separation, summarization, and findings report^{7,8}. The sixth step (consultation with specialists), considered optional, was not included.

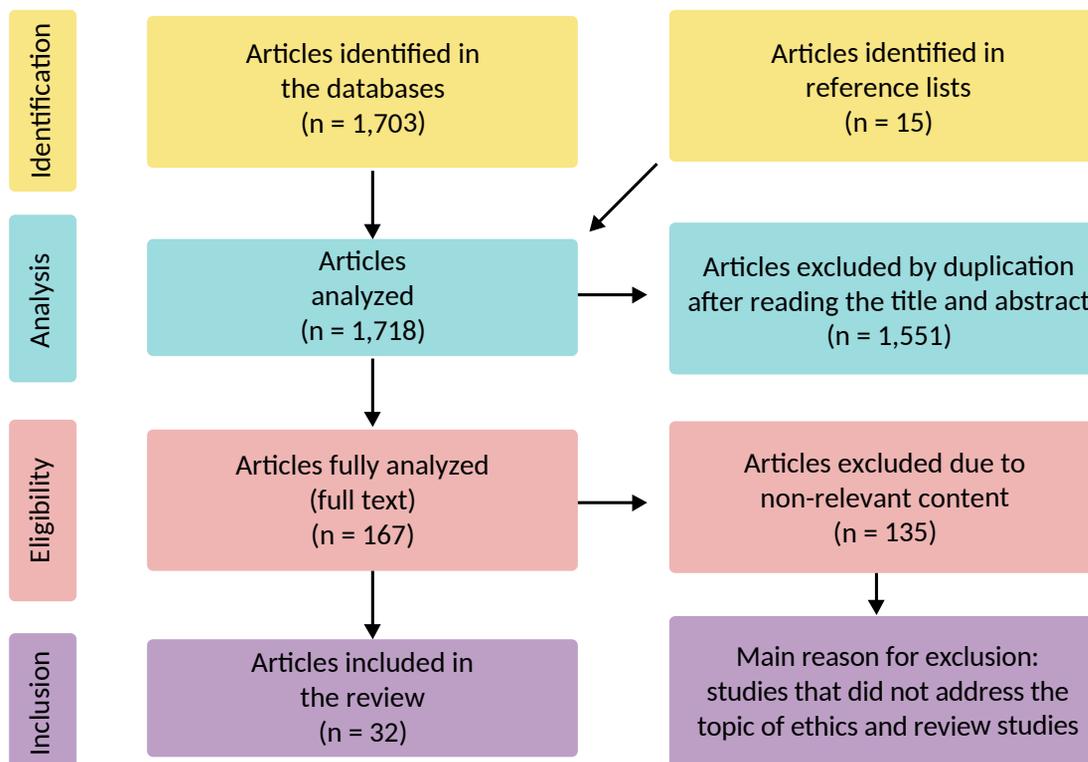
The scope delimitation followed the mnemonic strategy PCC (Population, Concept, and Context). Health professionals were the population; the concept of interest was the ethical aspects of patient safety, and the context analyzed was that of health services. Thus, the research question can be defined as: what are the ethical aspects present in the context of patient safety in health services? The Scientific Electronic Library Online (SciELO) and Virtual Health Library (VHL) indexes served as data sources, which include the Latin American and Caribbean Literature in Health Sciences (Lilacs), Spanish Health Sciences Bibliographic Index (Ibecs), Medical Literature Analysis and Retrieval System Online (Medline), Nursing Database (Bdenf) and Cumulative Index to Nursing, and Allied Health Literature (Cinahl). Google Scholar and reference lists of relevant texts were also checked.

The following controlled descriptors, registered in the *Medical Subject Headings* (MeSH) or *Health Sciences Descriptors* (DeCS), were selected: *ethics*; *bioethics*; *professional ethics*; *patient*

safety; and *medical errors*. The terms were also searched using their correlates in Spanish and Portuguese. The search strategy used followed the definition of each corresponding database. The Boolean operator “and” was used in the following combinations: “ethics and patient safety”; “ethics and patient safety and bioethics”; “professional ethics and patient safety”; and “ethics and medical errors”. These search strategies, also adopted in their Spanish and Portuguese correlates, were carried out in September 2019.

Original articles, theoretical studies, experience reports, case studies, and editorials, published in Portuguese, Spanish, or English, addressing patient safety and ethics were included. No time limit was defined. Duplicate texts, reviews, theses, dissertations, and newspaper articles were excluded. The PRISMA Extension for Scoping Reviews (PRISMA-ScR)⁹ methodology was chosen to systematize the inclusion process. The studies were pre-selected from reading the titles and abstracts, and the final sample was reached after reading the pre-selected articles in full (Figure 1).

Image 1. Flowchart of study selection according to the PRISMA Extension for Scoping Reviews method



Research

A structured instrument in Microsoft Excel was used to extract the data and identify the essential elements of the studies. This mapping allowed for synthesizing and interpreting the data, resulting in a numerical description of the texts included in the review. Thus, the separation, summarization, and findings report stage were carried out to present an overview of all the material according to theme categories.

Results

After evaluation and selection of articles, 32 studies, published between 2004 and 2019, were included in the scoping review. The results are presented below, with a general description of the characteristics of the studies, followed by observations on seven categories evidenced in the analysis of the *corpus*: 1) organizational and team factors; 2) communication with the patient; 3) incident reporting; 4) beneficence and non-maleficence; 5) justice; 6) autonomy; and 7) elements enhancing ethics in patient safety.

Description of the studies

Most studies were published in 2015 (n = 4)¹⁰⁻¹³, followed by 2019 (n = 3)¹⁴⁻¹⁶, 2017^{17,18}, 2009¹⁹⁻²¹, and 2007²²⁻²⁴, with two studies each. The papers were published in 28 journals, among which only two had more than one publication: *Nursing Ethics* (n = 4)^{16,25-27} and *HEC Forum* (n = 2)^{28,29}. As for the location, most of the research was conducted in the United States (n = 11)^{11,19,20,22,24,29-34}, followed by Brazil (n = 3)^{17,21,35}, Spain (n = 2)^{10,14,36}, and Iran (n = 2)^{16,18}. Other countries, such as Australia²³, Canada²⁵, Colombia³⁷, Finland³⁸, India¹², United Kingdom¹⁵, and Sweden³⁹ presented only one text. Of the 32 studies, seven included nurses in their sample^{11,15-17,31,35,39}, one included managers²⁹, and another included bioethics specialists³⁶.

Organizational and team factors

This category comprises service organization factors: lack of resources, turnover, shortage of human resources, management failures, work overload, and neglect of the health system. The following stands out regarding the factors related

to the team of professionals: team competence, lack of knowledge, and impaired performance.

The findings indicate that organizational factors are the ones that most affect the ethical aspects of patient safety. Such factors are related to the inability to provide optimal care due to lack of resources^{1,32}, high turnover of professionals, and shortage of human resources in the care environment¹³. Nurses reported that most incidents are caused by excessive work^{15,27,32}. Likewise, a study that investigated medication incidents identified lack of attention/knowledge and overworked professionals as the main causes for the issue²¹.

Another study points out confidentiality and privacy issues concerning the electronic medical record related to the use of electronic systems that fragment information, impairing access and increasing data inaccuracy²⁵. A different research⁵, on the other hand, states that overworked professionals tend to misinterpret the medical prescription recorded in clinical records.

King³¹ showed that systemic negligence – including non-medical factors, such as a lack of political and social interest – can cause a lot of damage to a health system. This negligence is the cause of failures such as irregular supply and low quality of medication, incorrect diagnosis, delay in referring patients to specialized care, poor care, and lack of infection control (for example, the spread of tuberculosis in African countries)³¹. Thus, events that should be considered unforgivable in a health system are perceived as normal³¹.

To a lesser extent, personal factors related to health professional's activity were verified. Research mentions a deficit in knowledge and skills among professionals, elements that can threaten patient safety⁶, as well as incompetent staff^{1,32}. Arksey and O'Malley⁷ also report the risk of impaired performance due to alcohol abuse and mental or physical illness, in addition to abusive or destructive behaviors.

Communication with patient

In this category stand out aspects related to communication with the patient, their family, and the health team. The studies refer to both adequate communications, with truthfulness, clarity, transparency, sincerity, and honesty, as well

as inadequate communication. The results show that the main benefit of good communication is the increase in trust between professionals, patients, and family members³⁶. Outstanding conduct is the participatory dialogue, based on symmetrical interpersonal relationships⁴⁰.

Kadivar and collaborators¹⁸ emphasize that it is the professional's obligation to inform the patient or family about each unwanted event, that is, the injured patient has the right to know what happened^{10,22,24,30}. Giraldo and collaborators³⁶ agree that not only the fact itself should be communicated to the patient but also the causes and possible solutions for the error. In this sense, the basic characteristics of an apology should be sincerity, clarity, and honesty. It is up to the professional to reveal what happened to the patient in a responsible manner, respecting the ethical principles of their profession, and valuing dialogue⁴⁰. The ethical response to an adverse event begins with the humility to speak honestly about the mistake^{13,24,34}. Thus, the patient can make informed decisions about future treatment options²², even if the option is for the interruption of treatment at the institution where the error occurred³⁴.

Pavlish and collaborators¹¹ point out that the lack of open communication with the patient may be due to cultural, religious, and moral differences. It is also common that inadequate communication happens due to asymmetry of knowledge, since, while health professionals have a high degree of specialization, patients and family members often face unprecedented situations and may have difficulty understanding information and making care-related decisions³². In this sense, Milos and Larraín¹⁰ indicate that nursing professionals occupy a strategic position since they gather information from both the patient and the various health professionals.

Incident reporting

This category addresses issues related to communicating the incident to the patient, their family, and the institution. The following aspects stand out: fear of communicating an adverse event and fear of facing repression, punishment, or embarrassment.

Fear of legal consequences or the reaction of the media and professional colleagues is one

of the barriers to reporting of incidents³⁶. Thus, it is common for professionals to not report adverse events to the patient and other instances for fear of reprimands, dismissal, or loss of respect by their peers. In some cases, professionals perceive such incidents as being of minor relevance, having no need to report them¹¹.

The results also show that professionals are afraid of being subjected to lawsuits for negligence³⁰. A study states that professionals avoid communicating adverse events to patients with the justification that they are unprepared to face the situation¹⁰. Coli, Anjos, and Pereira³⁵ also call attention to the fact that nurses' and doctors' academic training reinforces the premise of incident-free care, perpetuating the message that mistakes are unacceptable. The culture of punishment makes it impossible to discuss the facts in a critical and constructive way so that even professionals who report errors honestly are continuously treated as guilty⁴¹.

Even professionals in leadership positions are afraid to defend themselves against a legal claim, as it can be time-consuming, embarrassing, and personally humiliating. The findings, therefore, indicate fear as the main barrier to the communication of adverse events³⁴. The culture of fear discourages the disclosure of information to a patient who may become a witness for the accusation against either the institution or the professional³⁴.

Beneficence and non-maleficence

In this category, aspects related to the principles of beneficence (achieving good) and non-maleficence (minimizing the damage caused to the patient) stand out. Beneficence refers to the moral obligation to prevent harm²⁴ and to do good²⁷, while non-maleficence refers to the moral obligation to not cause harm.

Beneficence is threatened when incidents are not reported, as the failure to report prevents other professionals from having access to relevant information and avoiding the same mistake²⁴. The principle of non-maleficence, on the other hand, is violated in all incidents committed against the patient^{24,27}. The lack of honesty in communication and the lack of commitment to seeking solutions to adverse incidents disrespect both beneficence and non-maleficence³³.

Respecting the principle of non-maleficence also involves applying practical guidelines and procedures to prevent harm (for example, sterilizing materials, washing hands, etc.)¹⁵. Failure to implement these practices compromises patient safety. The duty of non-maleficence applies even after the adverse event has occurred, since the health institution can cause even greater harm by not being honest with the patient³⁴. On the other hand, respecting the principle of beneficence requires more from the professional, who must take positive measures to help others, and not just abstain from harmful acts. It is necessary, for example, to keep up to date and create standards of practice that promote benefit¹⁵.

Ethics and patient safety are intertwined. We expect all patients to be treated with dignity^{18,26} and protected from any possible harm¹⁸ – that is, it is the professional's moral obligation, above all, to not cause harm³⁰. Thus, beneficence and non-maleficence are connected to the patient's rights, the safety of care, and health services that guarantee a care free of danger or risk of injury⁴².

Justice

This category comprises aspects related to the principle of justice: commitment to the public good, awareness of problems and social injustices, equitable distribution of goods and services and responsibility for the quality of care.

Every patient has the right to fair, equitable, and adequate care. However, social inequalities, particularly in access to care, complicate the discussion on the topic of justice. King³¹ defines injustice as any act or omission negating the patient's rights. On the other hand, an example of justice mentioned by the author is the consistent application of nursing practice standards to all patients, regardless of economic, educational, cultural, religious, racial, age, or sexual differences³¹.

The equitable distribution of benefits (the patient's right to receive a fair share of benefits, burdens, and risks) is related to the principle of justice³⁴. According to this principle, the patient's interest precedes the professional's concern regarding legal consequences, with the affected

person not being responsible for the burden of the non-communication of adverse events³⁴.

Doing nothing and allowing innocent people to be hurt and die is an injustice not only for those immediately affected, but also the poor, impotent, and marginalized who lack access to assistance, since health care costs skyrocket as a result of adverse incidents³³. Thus, Clark³³ states that the waste of resources in incidents is a serious injustice against all citizens, while minimizing incidents means ensuring patient's safety and acting fairly³³.

Autonomy

In this category, aspects related to autonomy stand out, that is, what each patient or family, by exercising their will, decide regarding their own care. The results indicate that autonomy refers to the patients' right to choose and the professionals' obligation to respect their choices³¹. This does not concern a duty, but a patient's right³¹. Examples include informed consent and treatment refusal³¹. The topic of autonomy comes up in 7 of the 32 texts that make up the research *corpus*^{21,22,24,27,29,31,34}.

The patient who can understand and contemplate the risks, benefits, and alternatives of a particular treatment is sufficiently capable of engaging in the informed consent process³². But the principle of autonomy is only truly respected when the professional fulfills the duty to guarantee the patient's right to direct the course of their own life and make decisions about their own care³⁴. In this regard, respect for autonomy is crucial accountability for all professionals, as if they advocated for the patient²⁴. There are two simultaneous responsibilities: balancing the duty to avoid risks (security) and the respect for autonomy (choices)²⁷. When an adverse incident is not reported, the patient does not have the information necessary to self-determination²². Consequently, their freedom to make decisions is curtailed.

Nelson and collaborators²⁹ showed that limiting patient rights is the most frequently identified ethical concern. Some examples of autonomy restrictions are: disrespecting the rights of a person who has shown violent behavior towards employees or other patients; restricting the availability of treatment to patients perceived as

“abusing” the system; and reducing options for admission or therapies for patients who have a history of poor adherence to treatment²⁹. These situations often represent conflicts between personal rights (patient autonomy) and the institution’s security policies²⁹.

Elements enhancing ethics in patient safety

This category highlights elements that enhance the role of ethics in patient safety: ethical education, communication skills, academic training, committees, notification systems, and organizational culture. Of these, ethical education stood out the most in publications^{11,16,17,26,30}. Kangasniemi and collaborators²⁶, for example, propose that the main challenge for nursing is giving visibility to ethical issues related to patient safety. Another study with nursing staff leaders suggests that institutions should provide education and develop policies and practices to promote ethical actions and teamwork¹¹.

Ethical education is also perceived as a major challenge³⁰. Barkhordari-Sharifabad and Mirjalili¹⁶ point out that providing training programs for ethical leadership in nursing in the form of a workshop could help to reduce incidents and improve patient safety. Another study¹⁷ highlights the importance of the nursing staff’s continuing education, with training based on operational procedures and protocols in the area, to prevent medication-related mistakes¹⁷.

Another topic brought up in the studies is the need to foster communicative skills²⁹ and the professionals’ legal knowledge before reporting incidents, through support and training³⁶. Thus, specific communication and apology programs that have institutional support must be implemented⁴³.

Another element addressed by the studies analyzed is the undergraduate curricula, which should comprise content and skills necessary for professionals to understand patient safety, as well as ethical duties and legal obligations that integrate care management^{10,21}. Arries²⁵ also points out the need for curricular changes for nurses to develop essential skills, such as computer skills, evidence-based practice, and quality of care improvement.

The author also proposes that professionals and patients should be involved in the institutions’ ethics committees²⁵. Likewise, Pavlish and collaborators¹¹ consider that mutual trust between staff and service management is a key element for the quality and ethical character of care.

The findings indicate that adverse incidents should be widely reported as soon as possible, so that services can change protocols and prevent similar accidents from happening in the future³⁰. Hence the need to create a notification system that respects the confidentiality of the professionals who report cases²⁴. Anonymous incident report is widely recognized as an important strategy for improving incident notification rates, and reducing risks and incidence of failure in health services⁴¹.

According to Erlen²², organizations must be able to document and evaluate what is taking place to identify problems and implement new practices, rather than just blame individuals. Strategies to reduce incidents include surveillance, changes to the organizational culture, and the creation of a safe environment, that is, an environment relying on reports that widely disclose unsafe practices and incidents²². These strategies must be implemented at all levels, for all professional categories, as no professional is immune to making mistakes²². Disclosing incidents to patients should be part of the health care routine³⁴. That is why Clark³³ suggests that legislators create public policies to minimize health incidents and protect the patient, prioritizing human life.

Discussion

Currently, patient safety is affected by two essential aspects of health services: the organizational, which structures the system’s practices, and the technological, which determines the performance of these practices. Macropolitical (organizational) and micropolitical (technological) changes in work have profound consequences for the ethical exercise of professions, with implications for patient safety. These transformations radically change the focus of ethics, which then moves from intentions to results, representing a transition from an ethics of conviction to an ethics of responsibility.

What matters for the ethical exercise of the profession is the result of the action for the patient, dependent on the organizational and technological aspect of the work, and not so much the intention of the action. Thus, professionals are evaluated based on the results for the recipients of the practices. That is how responsibility becomes a core category.

This section discusses the data presented based on the ethics of responsibility proposed by Max Weber⁵ and Hans Jonas⁶. The first three categories identified (organizational and team factors, communication with the patient, and incident communication) relate to the organizational aspect of health practices and have the responsibility for the results of the actions as an ethical reference, especially the negative results for the patient's safety. Three other categories refer to principles of bioethics (beneficence and non-maleficence, justice, and autonomy) and concern the technological aspect of health practices. This aspect demands understanding responsibility as an unequal, non-reciprocal relationship of respect for the subjectivity of the patient as a requirement to ensure their safety. Finally, the last category (elements that enhance ethics in patient safety) can be critically discussed when ethics is understood from the perspective of responsibility.

The category concerning organizational factors is related to the staff's competence, lack of resources, turnover, and overload. Nora, Zoboli, and Vieira⁴⁴ showed that working with incompetent colleagues can increase the chance of experiencing ethical problems. Adverse consequences are not caused intentionally by the professionals, but result from organizational factors that must be evaluated ethically, from the perspective of the system's responsibility, and not personal beliefs. Therefore, both administrative failures and knowledge deficiency on the part of the professionals are organizational factors. Despite not resulting from intention or conviction, adverse results cause moral suffering, as the professional is usually held responsible for organizational problems.

The items most frequently mentioned in the category of communication with the patient were: clarity, transparency, honesty, and truthfulness – characteristics that also depend on organizational factors, both verified

and evaluated by results, and not intentions. Such characteristics must be seen as an ethical reference for managerial responsibility. Biasibetti and collaborators⁴⁵ corroborate this statement by showing that good communication guarantees the quality and safety of the care provided. Nora, Zoboli, and Vieira⁴⁴ refer precisely to the inadequate communication with the patient, with the omission of information, as one of the ethical issues experienced by professionals. Such problems, as stated, are related to organizational structures and conditions, and institutions should be attentive and take responsibility for the effects of communication on professionals and patients. Thus, the health system must develop effective communication channels across the team⁴⁶, as well as facilitate means for honest and responsible dialogue, improving the professional-patient relationship^{37,47}.

Another important category was incident reporting, touching on aspects such as fear, punishment, embarrassment, and pressure. Fear of punishment and exposure for the professional are factors that limit notifying mistakes and adverse events⁴⁶. To reverse this scenario, we must provide the professional with open and effective communication, preventing them from experiencing feelings of fear, shame, confusion, uncertainty, insecurity, and frustration⁴⁸. Such feelings arise when the conception of ethics fully falls over the individual's intentions and convictions, making them feel guilty. On the other hand, if the main focus falls on the results, dependent on organizational and technological aspects, the ethical dimension can be perceived from the perspective of shared responsibility. Communicating adverse events would not give cause to fear and embarrassment or stimulate the tendency to hide information. On the contrary, dialogue would be encouraged to facilitate the analysis of organizational and technological aspects leading to the incident, not to seek a culprit, but to reflect on changes to prevent the same mistake from happening again.

The findings on beneficence, non-maleficence, justice, and autonomy, in their relationship with the ethical dimensions of security, refer primarily to the technological rather than the organizational aspect of health practices. Here, the non-reciprocal and unequal relationship, the possibility of causing

harm, and the future perspective of health practices appear as central elements of responsibility. In this sense, the principle of beneficence encompasses non-maleficence in the commitment to assess and prevent predictable damage. Thus arise the two central dimensions of responsibility⁶: the prediction and the possibility of harm in a non-reciprocal and unequal relationship, as is the case in situations where the patient's safety is involved.

Such understanding of responsibility takes place when one understands autonomy as the ability to establish one's own rules – that is, the ability to think, decide, and act. Recognizing this ability while respecting the patient's human dignity and their decisions is an ethical principle for professional conduct⁴⁹. This means guaranteeing the patient's well-being and rights, recognizing that the more invasive and liable to damage the procedure, the further it must be clarified, justified, and supported by the patient's consent⁵⁰. As the clinical relationship is unequal and non-reciprocal, it is up to the professional to take responsibility for the results of their actions, foreseeing and preventing risks and damages.

Justice also came up in the research. A study⁵¹ identified that the culture of justice recognizes that inequality in the distribution of resources does not depend on individual causes, but the inefficiency of the system. Therefore, the responsibility for injustice and failure to achieve promised and expected social results are systemic and dependent on organizational aspects.

Regarding the elements that enhance the ethics of patient safety, permanent education in daily professional life is pointed out as a way to create a culture of safety in the workplace. For Nora, Zoboli, and Vieira⁴⁴, this education could develop ethical skills. It is worth pointing out, however, that the ideal model for this daily learning would be based on the ethics of responsibility, focused on the result of actions, and not the professionals' convictions⁵, as well as considering the non-reciprocal and unequal relationship of responsibility, the possibility of harm, and the prospect of projection into the future⁶.

As a main result, health services should develop clear and evidence-based guidelines to promote an

organizational culture focused on patient safety. This implies that professional training is continuous and focused mainly on ethical skills and the ability to deal with technology. In this sense, institutions should develop and implement educational and counseling programs for professionals, addressing ethical principles of care security, communication skills, incident reporting, patient rights, and management of emotional, ethical, and legal aspects.

The process of enhancing patient safety ethics does not take place within a moral vacuum, reason why the ethics of responsibility model is imperative. There must be knowledge and understanding of practical, associated with patient care and safety programs, and organizational issues¹⁴. Patient safety, which should be a national priority¹³, will only be effective if responsibility becomes the foundation of ethical relationships in health services.

Final considerations

Organizational and team factors, communication with patients, report of incidents, beneficence and non-maleficence, justice, and autonomy were elements identified in the present review and discussed based on the ethics of responsibility. The results can be useful for health professionals who work in patient care. Since incidents are part of health services' daily routine, professionals must be prepared to deal with ethical issues from the perspective of responsibility. The study can also help managers and specialists to be attentive to the technological and organizational aspects that involve patient safety.

We conclude that there must be permanent educational processes on ethics and patient safety in place to improve professionals' communication and sensitivity skills to navigate situations related to incidents, becoming aware and taking responsibility for the results of their actions. We believe that, when damage (or the possibility of damage) takes place in care, it should be used as an opportunity to investigate the problem, educate the team on safety culture, and create new policies regarding practices that promote the responsibility for incidents, mitigating their effects.

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Carlise Rigon Dalla Nora designed the study and, together with José Roque Junges, wrote the manuscript, analyzed the results, critically reviewed the article, and approved its final version.

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