**Ethical Traps for NHS managers:** an NHS Confederation Salon. 30 January 2007

## 1. Note of the discussion:

### Causes of unethical behaviour

An initial discussion of examples of behaviours or decisions that could be considered unethical suggested these were illustrations of one or more of the following:

- judgements/ decisions/ actions taken by individuals who themselves 'occupy a lonely position in a web of social relations'. So individuals act within a wider set of organisational and other relationships, and are informed by expectations forged over time.

- behaviours now seen as unethical which have developed over time through a process of 'normalisation of deviance'

- adverse incidents that happen because a series of improbable incidents 'line up', like the holes in Swiss cheese.

- dissociation, the defence that develops to deal with 'emotional labour', and which increases the ability to behave unethically or even brutally.

- lack of confidence in one's ability to challenge effectively.

### Promoting ethical behaviour

Two contrasting approaches to promoting ethical behaviour were advocated at different times during the discussion: *rules* and *personal embodiment*.

*Rules to guide ethical behaviour*

There are a number of sets of rules governing different groups of people within the NHS, these include the Nolan principles, professional codes of conduct, and a plethora of operating policies and protocols. Relying on these to result in ethical behaviour can be problematic because:

- there are situations where it is not possible to stick to them. These are either situations not envisaged when the rules were codified, or ( and/or) genuine ethical dilemmas where there is no 'right' answer.
- if we insist on people sticking to the rules we require them to suspend their judgement and we diminish their ability to exercise it.
- many ethical areas are intangible (e.g. while aspects such as fraud or corruption are relatively straightforward those to do with respect for persons or bringing an organisation into disrepute are much less so).
- these can tend to be dominated by lawyers rather than either ethicists or those closest to the dilemmas the rules try to cover.
- they can lead to ethics being pushed down to too local a level, a level without the right skills or capability, and without support.
- at best, rules may reduce unethical behaviours but they do not increase ethical ones, since we are much better at defining and devising sanctions for the unethical than we are at describing and rewarding the ethical.

*Personal embodiment*

This was described as a *physical disposition* to behave ethically, and as:

- rebirth of ethical values on an ongoing basis
- a belief in the right of others to good care, regardless of whether you like them
- indeed an ability to understand and overcome even strong feelings of dislike.

There was in general more support for this as an avenue that allowed the complexity of many of the ethical traps to be explored, while being wary that this approach could be caricatured as a policy of 'just recruit saints'.

There seems to be an implicit understanding of the importance of personal characteristics on a wider basis: it was pointed out that attributes such as courage, wisdom, sense of humour, tenacity are deemed more important than technical knowledge for people handling complaints (in local government) for example, and 60 % of complaints in the NHS are about 'attitude'.

The interaction between physical and ethical can be seen too in the suggestion physical reactions can alert people to ethical problems, for example, a major obstacle to the feeling of being 'in the flow' is the experiencing of an ethical dilemma.

There was perhaps a 'strong' form and a 'weaker' form of the physical embodiment theory present in the room, with the former suggesting that 'for the words to be found the feelings have to be endured' and the latter suggesting that 'faking it' could be

valuable, and perhaps the two coming together in the suggestion that 'faking it can lead to becoming it'.

We also saw that someone's underlying attitude to risk and to the exercise of power will affect their emotional and physical reactions to situations in that if we aim for control we will experience physical discomfort about uncertainty and at the 'humiliation of not knowing'. If the aim is, instead, for growth through the acceptance of risk then uncertainty and ambiguity are opportunities for increasing self (and organisational?/ contextual?) awareness. There was general agreement on the importance of mindfulness, of being present, of responding 'in the moment'.

**The role of the organisation and its leaders in promoting ethical behaviour**

There was a concern at the current lack of organisational interest in ethical behaviours. We heard for example that in spite of the underlying principle of medicine being 'first do no harm' – *primum non nocere*) Boards do *not* see safety as their *first* idea. There are many actions they could take to reduce the harm experienced by patients of their organisation but they do not give these priority.

Organisations do not think clearly about how and when to apportion blame. Instead of recognising three distinct and legitimate levels of culpability:

- the deliberate setting out to harm
- setting oneself up so that one is capable of harm through disorganisation etc
- skills based error

there is a tendency to write detailed rules and policies (to be added to all the other detailed rules and policies which are often then only consulted once a problem has already arisen) which allow blame to be laid on the front line.

And on a wider basis there is an implicitly utilitarian managerialist (economist) ethos with an emphasis on efficiency and effectiveness, which fails to compute patient suffering and thus does not know how to value supportive care and palliation. Not only is this unethical it is self defeating because unless we revisit our concept of efficiency and effectiveness and find different ways of conceiving of them we will find our interventions are increasingly not contributing to wellbeing.

**There are genuine ethical dilemmas**

We saw examples where a choice has to be made and where one option can be supported using a utilitarian approach while another would be advocated using a deontological one.
So it is probably worth remembering that an understanding of these concepts and a concern to increase the ethical literacy of managers and organisations will increase

ethical performance, but they will not entirely eliminate ethical dilemmas, nor the difficulties of reaching a decision in these cases.

**2. Is there anything we can do to increase ethical performance and/or ethical literacy in NHS organisations?**

There was general agreement on the need for ethical discourse within organisations and that this must include managers and management teams. One way of using the energy of the discussions on the 30th may be to start a conversation about the nature of this ethical discourse. We saw, in the course of the discussion, the importance of this not being reified and separated from the day to day however its current absence suggests there is value in bringing it to people's attention.

A number of questions can be framed from the Salon discussion, even though it was relatively short and limited in its scope. If we were each to reflect on them and contribute our thoughts these could then be refined, elaborated and/or expanded and then be made available more widely as an informal discussion paper.

So the following set of questions are a first attempt in that spirit: a prompt for further debate between us.

*Questions a manager might discuss with their team, at any level within an organisation:*

*First do no harm : caring about care*
In what ways are we[1] failing to protect patients from being harmed while in our care?

How can we keep our reactions to someone's experiences fresh, so that we care about those experiences and do not dissociate from them?

How do we know what patients are feeling and experiencing?

Do we all have a shared sense of the 'task' of the team?

How are we valuing support and palliation compared with 'treatment' and 'cure'. Do we understand how these contribute to wellbeing? How do we translate this into our sense of our task?

*Developing and managing ethical performance*

[1] It would be most valuable if the team answered for themselves personally as well as on behalf of the team: so for 'we' read 'I/we'.

What does *ethical* behaviour look and feel like in our context?

What opportunities are there for people to raise what they perceive as ethical dilemmas?

What human rights could we be compromising in

- the way we offer our services,
- how we distribute them, and
- how we treat our patients/users
- and staff?

Are we as individuals and as a team taking appropriate authority? Using it judiciously?

Are there examples of where we have pushed ethical decisions down to a level that is not equipped ( perhaps does not have authority, resources, skills or time) to deal with them?

How do we respond when someone reports an adverse incident? How do we know how we respond – what information do we collect and keep and present, about organisational responses to these individuals?

How do we make judgements about how much blame to apportion and where to place it?

When someone on the front line is blamed do we encourage /require reflection at more senior levels about what those more senior individuals could have done differently?

Are we a team? or a pseudo team?

As a team how can we develop ethically?

*Developing mindfulness*
Could we be described as a 'mindless' organisation or team by patients or others?

Does our desire for a diagnosis and a solution prevent us from staying 'in the moment'? How can we increase our ability to notice our uncertainty and doubt and stay with that without becoming disabled by it?

In what ways do we resist patients/users ( or staff) needs for emotional engagement, respect and recognition of their experience and rights, because we can't bear to stay, in the moment, with our own internal conflicts about those needs (so instead our actions become humiliating or persecutory to the other)?

*Interactions with other parts of the organisation or system*
When human rights are being negated, in terms of expectations of and behaviour towards employees, where does such bullying originate (inside or outside the organisation, where within the organisation ) and how can we stop it within this team?

How do we know what our own staff and others with whom we interact are feeling and experiencing?

In what ways are we lying, demonstrating hypocrisy, or being otherwise dishonest with the public or other parts of the system (health, social care or political)?

If 'every part of the system says something profound about the whole' what do we as a team say about the wider organisation?

*Questions of any manager*
Am I making sure that people are doing what they are supposed to be doing?

Am I taking appropriate authority? Using it judiciously?

*At the top of the organisation:*
How real is the governance role of our Board? Do we empower non-executives to challenge in a meaningful way?

In what ways do we punish people who do take an appropriate level of accountability and reward those who do not?

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Developing people and services in health care