Accountability and intuition: justifying nursing practice

This article examines how promoting individual accountability and justifying nursing practice using scientific evidence appear to contradict theories of intuitive nursing. The author considers the professional and legal implications raised by the contradiction and advocates that evidence-based practice must be the justification in law for nursing action.

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Accepting that the concept of accountability should be central to each nurse’s practice signalled a new maturity in the nursing profession, and it was highlighted particularly in the Scope of Professional Practice (UKCC 1992a) and the Code of Professional Conduct (UKCC 1992b). That this concept continues to be important is emphasised in the paper on accountability in the Guidelines for Professional Practice document (UKCC 1996) which stated: ‘It [accountability] is an integral part of professional practice.’

The importance of accountability to current nursing thought and practice makes it essential to examine its meaning and how it relates to other current nursing theories, such as those found in naturalism, for example, phenomenology.

A phenomenological view of the world rejects conventional approaches to knowledge found in the natural sciences and, instead, attempts to interpret meaning from the participant’s point of view (Robinson and Vaughan 1992). This leads to assertions that expert nursing is largely intuitive and that the knowing is in the doing (Benner 1984, Darbyshire 1994), or that theory is lived by the nurse rather than being an abstract entity applied to the patient and that the knowledge inherent in the situation will always emerge (Newman 1994).

Newman rejected the objective empirical approaches to research and knowledge used by most of the other healthcare disciplines and presented this highly subjective version of theory as being in the tradition of her predecessors, such as Rogers (1970) and Johnson (1961). Reliance upon phenomenological perspectives implies that nursing is a largely subjective discipline and it is arguable whether its advocates have thought through the implications this has for the notion of accountability.

ACCOUNTABILITY AND RESPONSIBILITY

Any discussion of accountability must differentiate it from responsibility, a word nurses sometimes use loosely. Accountability means the nurse being able to give an explanation of and justification for his or her actions. Practising in this way requires a sound knowledge base upon which to make decisions in conjunction with professional judgment. This decision making process must be transparent, logical and replicable. If this were not the case, how could students ever learn nursing and how could a nurse be able to explain and justify actions taken?

Responsibility relates to carrying out instructions accurately and within an agreed time frame. The individual does not, however, initiate actions and make judgments. That is done further up the chain of command and responsibility to ensure certain tasks are carried out is delegated down to the individual. Those familiar with the concept of the extended role of the nurse will recognise this as the traditional way of working in nursing.

In current practice, student nurses and healthcare assistants are responsible for carrying out the instructions of the registered nurse. This responsibility extends to legal issues because a healthcare assistant or a student can be sued for negligence should either harm a patient (Young 1994). The registered nurse, however, is the one who is accountable. Responsibility does not, therefore, require the same knowledge base or decision making skills required by accountability.

Conversely, as accountability becomes more important in nursing practice, we have to question whether the education and training of nurses is ‘fit for purpose’ in this regard. The traditional training of ten or more years ago certainly fell short of the necessary standard. Even today it is questionable whether the diploma in health education is of a sufficiently high standard to give nurses the knowledge base and decision making skills to be truly accountable professionals within the increasingly complex healthcare environment.

Basic education for all other health professionals now extends to degree level. The statutory bodies in nursing have tacitly admitted the need to upgrade education because the level of education has been raised to degree standard for the UKCC Specialist Practitioner and ENB Higher Award initiatives.
BURDEN OF ACCOUNTABILITY

The burden of accountability is heavy because the nurse is accountable to:

- The UKCC which regulates practice. If the nurse falls foul of the Code of Professional Conduct (UKCC 1992b) disciplinary action will follow. This requires, among other things, acting at all times to promote and safeguard the interests of the patient and to justify public trust.
- The employer whose contract with the nurse will also make similar requirements in relation to the employer, as well as the patient, and will require compliance with the employer’s policies and protocols.
- The criminal law which is a codified set of rights and wrongs and which, among other things, requires the individual (the nurse) to do another person (the patient) no harm. The person is, therefore, judged guilty or not guilty of an offence as defined in law.
- The patient to whom the nurse clearly has a duty of care, of which a breach resulting in harm to the patient leaves him or her open to a claim for negligence in the civil courts.
- Himself or herself because the nurse’s own conscience normally induces a desire to ensure that he or she has done the best possible for the patient.

This range of accountability requires the nurse to be able to mount a strong defence of his or her actions with ample justification for decisions made. This is the problem with the concept that expert nursing is largely intuitive (Benner 1984, Darbyshire 1994, Newman 1994).

INTUITION AND OBJECTIVITY

Most nurses will be familiar with Benner’s view (1984) that nurses evolve from novices into experts and as they do so, their decision making becomes more implicit and intuitive as they move from rule-bound competency through proficiency to expertise.

Writers such as Benner (1984) have stressed the difference between ‘knowing how’ and ‘knowing that’. The ‘knowing how’ is knowledge embedded in practice (Schon 1983) in the reflective practitioner. These ideas have led to the rejection of conventional notions of what constitutes theory in other disciplines, such as medicine, that is, an explanation of relationships between concepts which tries to predict outcome. This is an objective and rational approach which has become refined in the latter half of the 20th century to include the notion of predicting outcomes only with a given probability rather than the mechanically deterministic model of the 19th century natural scientists.

Writers such as Rolfe (1993), however, argued for the rejection of this notion and its replacement with the idea that theory is generated out of practice in an informal way by each individual nurse. Knowledge and meaning are embedded in the situation and are, therefore, unique to each individual practitioner. Theory has now become subjective, each individual builds up his or her own version of theory to guide practice. These phenomenological perspectives are becoming increasingly popular as truth and knowledge are argued to be embedded in individual experience rather than in any objective reality (Newman 1994).

This raises the question: ‘Which nurse’s personal theory is correct?’ Presumably all are equally valid, in which case relativism and subjectivity replace objective theory and knowledge. According to Benner (1984), the consequence of this claim is that: ‘There is no higher court than the expert’s reading of a particular situation.’

There are major problems with this statement not least of which is who decides who is an expert? Even more problematic is that it appears to place the nurse above the UKCC and the civil law if he or she chooses to define himself or herself as an expert.

If the nurse is to justify his or her actions to the UKCC, the employer, the criminal law and the patient in civil law, is it enough to say ‘I did it my way’? Another nurse may interpret the same situation differently and act differently according to his or her own knowledge. Where does this leave the patient, the employer or the UKCC in trying to hold nurses accountable? It is like refereeing a football match with each player having a separate set of rules rather than one agreed common set, which would result in chaos.

Nursing practice must be measured against a codified set of guidelines. Examples include the UKCC Code of Professional Conduct (1992b), the criminal law, the employer’s contract of employment or a clinical protocol. The nurse must have evidence to support practice which can be scrutinised and which can be shown to apply across a range of patients and situations. Such evidence is supplied by theory, but it has to be theory which is rooted in objective reality rather than a subjective, personalised view which only serves to help the person be accountable to themselves.

JUSTIFYING PRACTICE

Judgment on cases of negligence in civil law is less clear as it hinges upon the Bolam Test, which involves a consensus of expert opinion. The Bolam test resulted from the case of Bolam v Friern HMC 1957 in which the judge ruled that a doctor was not negligent as he had acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular area. This is the yardstick against which any case for negligence will be measured and, given the conservative nature of the law, it is likely that the court will require justification for practice based upon evidence, that is, objective reality. The consensus required by the Bolam test is much more readily arrived at with research-based evidence than it is with subjective, individual opinions that vary according to the circumstances.

Subjective explanations of the nature of nursing knowledge led Bradshaw (1995) to ask: ‘How can we
be sure whether such knowledge is right or wrong? The problem is that this approach denies any absolute measure or yardstick as all things now become relative to the individual nurse. Objective reality is denied and it is replaced with relativism, including moral relativism which Bradshaw pointed out to be incompatible with ideas of right and wrong, which go back to Florence Nightingale’s time and are embodied in nurses’ codes of conduct.

Bradshaw’s critique of the phenomenological perspective adopted by many current writers follows on from Benner, asked: ‘If there is no objective agreement about right and wrong, how can a nurse ever be held accountable?’ Such a relativistic stance invalidates codes of conduct, evidence-based practice, protocols and contracts of employment while making it very difficult to sustain the Bolam test in civil law.

Cash (1995) went further in the critique of subjectivity, seeing Benner’s work as an obstacle to the development of nursing knowledge and accountable practice because it ‘retreats into the validation of practice by authority and tradition’. The claim that the knowing is in the doing absolves the nurse from having to produce the evidence to justify his or her practice, a convenient hiding place. This is the antithesis of accountable nursing practice.

Those who advocate the subjective approach do so by attacking the natural sciences’ reliance on objective reality, claiming it to be inappropriate for nursing. Paley (1996) presented an interesting account of this debate citing Darbyshire (1994) and English (1993) as exemplars of the two opposing views. Paley is rightly critical of the way some nurse authors have become stuck in a 1970s timewarp, rehashing the stale quantitative versus qualitative debate and failing to recognise the way the philosophy of science has moved on.

In a particularly telling point, Paley (1996) questioned Darbyshire’s assertion that there are no criteria for recognising expert practice other than the judgment of the relevant community. Paley wondered just who constitutes this ‘relevant community’ because, if this means expert nurses, then only an expert can know an expert and we are no further forward. If Darbyshire means nurses in general, then this omits the views of patients, NHS managers and other professionals in the multidisciplinary team. The nurse must be accountable to other team members and in the past nurses have been very critical of doctors who retreat from questioning behind the subjective smokescreen of ‘clinical judgment’. If nurses are not careful, they could fall into the same trap and attempt to avoid accountability to other professionals by claiming ‘expert status’.

One final point about accountability is that the nurse must have not only the knowledge to act autonomously, but also the authority. It is not enough to know what to do and to be able to justify those actions, the nurse must also be free to act in accordance with his or her knowledge base. Authority in health care is a valuable commodity which in the past has largely been monopolised by the medical profession. This is changing with the growth of, for example, the nurse practitioner movement.

However, if the nurse is to be given more authority to act autonomously, as an accountable professional, he or she must convince both the medical profession and NHS managers that he or she can be trusted with that authority, the point made earlier by Paley (1996).

CONCLUSION
Attempts at writing a new philosophy of science wrapped up in the sort of meaningless jargon which describes nursing as a ‘unitary transformative paradigm’ (Newman 1994), will engender little credibility with other colleagues in the healthcare team. It is this sort of philosophising from the US and Canada which has rightly been dismissed by Paley as amateurish and ill-informed.

Appeals to nebulous concepts of intuition and knowing in the doing will not impress an NHS trust or GP conscious of litigation and risk management. The nurse must be able to justify his or her actions with reference to an objective evidence base if he or she is to earn the authority that will make for truly accountable practice. Only in this way can nurses give a sound account of their actions which will stand up to scrutiny. And only then can nurses claim the accountability stated by the UKCC to be an integral part of professional practice and, therefore, be trusted with the degree of autonomy that they desire.

REFERENCES