Accountability in Nursing

Reflecting on Ethical Codes and Professional Standards of Nursing Practice from a Global Perspective

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The concept of accountability is a concept closely aligned with public trust and confidence with a healthcare discipline. It is of vital importance to the discipline of nursing to define and examine the obligations and duties of professional nurse. The term is referred to and often defined through international and national professional codes of nursing and in standards of nursing practice documents. This column will begin exploration of the concept with offering a definition from a human-becoming perspective.

Keywords: accountability; humanbecoming; nursing standards of practice; professional codes of nursing

From a global health perspective, the term accountability is frequently understood and referred to as an important legal, ethical, and moral term reflecting an attitude of human obligation to other persons, groups, organizations, and societies. In global healthcare arenas, accountability is cited in accordance with international, national, and specialty nursing organizations’ codes of ethics, and in professional scope and standards of nursing practice statements found within the discipline of nursing. What are the current, prevailing definitions of this concept? From a nursing theoretical perspective, what are possible meanings of the concept and ethical implications for professional nursing practice, and the discipline’s obligations to all of humankind and the societies in which they live? Ethical questions of an ethos or straight thinking surface as the discipline of nursing struggles to answer these questions. Through the use of case studies, this article is intended to begin a discussion about possible ethical dilemmas surrounding the disciplinary concept of accountability for professional nursing practice.

To begin, what are the possible emerging definitions of accountability that are found in society today? Accountability in society is viewed as an essential element in the global, public healthcare arenas. Expectations abound in a pluralistic society whereby recipients of healthcare services are articulating desires for less paternalistic and authoritarian approaches in healthcare practices. Persons live with global healthcare structures that are state-welfare oriented and professionalized. The worldwide economies of nations and continents are globalizing with emerging technologies, burdening economic costs of healthcare, cycles of poverty, and limitations with access to healthcare services, questions of justice, and hunger, and yet simultaneously, in some areas of the globe, persons are faced with transforming limits of advanced technology in healthcare. With the ever-increasing complex technology and the ever-rising human and capital economic costs of healthcare to serve the globe’s people, ethical questions surface for how, to whom, and what the obligations and practices the healthcare professional is accountable for. What is the discipline of nursing’s accountability to the diverse peoples of global societies?

Codes of Nursing and Accountability

International and national codes of ethics and professional standards for nursing practice statements incorporate the concept of accountability. The emphasis of accountability is placed with the individual nurse. According to element 2 of the International Council of
Nurses (ICN) 2006 code of ethics, the nurse carries personal responsibility and accountability for nursing practice and for maintaining competence by continual learning. The American Nurses Association (ANA) (2001) code of ethics emphasizes that the individual nurse is to accept responsibility and accountability for individual nursing practice. The nurse is also responsible for determining the appropriate delegation of tasks consistent with the nurse’s obligation to provide optimum care. According to the ANA 2001 code of ethics, the individual nurse retains accountability and responsibility for the quality of practice and for conformity with professional standards of care. Professional nursing practice includes direct care activities, acts of delegation, and other responsibilities such as teaching, research, and administration. As the scope of professional nursing practice becomes more complex, the individual nurse must exercise judgment in accepting responsibilities, seeking consultation, and assigning activities to others who implement nursing services. Statement 4.2 of the Code of Ethics for Nurses (ANA, 2001) states that accountability means to be answerable to oneself and others for one’s own actions. In order to be accountable, nurses act under a code of ethical conduct that is grounded in the philosophical ethical principles of fidelity and respect for the dignity, worth, and self-determination of persons. Thus, individual nurses are accountable for judgments made and actions taken in the course of provision of nursing services. Clearly, national, state, or provincial regulatory agencies assign responsibility and accountability for professional nursing practice through regulations that include broad, yet legally binding statements for the scope and standards of responsibility and action for individual professional nursing practice. Some organizations have also discussed the concept of accountability from an organizational perspective.

Freedom to Care is a nongovernmental organization based in the United Kingdom. It supports whistleblowers and promotes public accountability of large organizations. From their perspective, organizations are nothing more than individual people arranged and trained to transform an apparently alien nature where organizations take on a life of their own, lose direction, and begin to contribute to transforming people in unexpected, and often harmful ways (Freedom to Care, 2008). With this view, organizations are greater than the sum of their individuals. It is believed and accepted that organizations need to be accountable. Accountability is “a preparedness to explain and justify one’s intentions, actions and omissions to stakeholders” (Freedom to Care, 2008, p. 313). This not-for-profit group also believes that organizational accountability is not to be understood merely in financial, legalistic, and formal terms. It is a matter of attitude where legal accountability may or may not help to promote a culture of willingness and preparedness to explain and justify actions to all those influenced by the consequences of chosen actions.

### Values and Nursing Ethics From a Nursing Theoretical Perspective

In serving others who are living health and quality of life through the disciplinary practice of professional nursing, chosen ways of being in the nurse-person relationship are not value free, objective, or without judgment. Limitless questions abound for what nurses should do and ought to do or perhaps should have done. Questions and spoken-unsaid doubts emerge and surface in the moment and linger with the nurse, while simultaneously moving on with other important nurse-person relationships. The author proposes that each nurse assumes responsibility and nursing accountability all-at-once while choosing valued nursing practice priorities from some philosophical lens of understanding. The philosophical lens includes paradigms, theories, principles, assumptions, and beliefs about the phenomenon of interest in nursing, including values and beliefs for what it means to be a human. Also, it includes what it means to be open to beliefs about meaning found in the universe or environment, and the potential meanings for health and quality of life. From a nursing theoretical school of thought of humanbecoming (Parse, 1998, 2007), all human decision-making is undergirded with the differing, unique values, beliefs, and cherished priorities of the person(s) choosing to live a path of direction with health and quality of life. Being and bearing witness with others as they live health and quality of life illuminates the integrity, cherished priorities, and values of the nurse, and the cherished priorities and valued desires of human dignity and worth for those who are receiving nursing services. Patterns of relating arise with diversity and are everchanging in the nurse-person relationship. Nursing’s priorities are relational, imbued with integrity, and interdependent. Nursing practice is a chosen way of being with others where the attention is on health from the perspective of “human freedom and dignity with the realization that human reality is cocreated illicitly, lived with paradox, constructed with freedom, and filled with impenetrable mystery” (Parse, 2007, pp. 309-310). Persons structure meaning, configure rhythmical patterns of relating, and cotranscend with the possibles while bearing witness with others as they construct a personal reality for living health and quality of life that
arises with inherent freedom in the impenetrable mystery of being human (Parse, 2007).

Questions of values and value priorities are closely related with questions of responsibility and accountability in the discipline of nursing. Individual accountability or answerability is interconnected with the relational integrity of the nurse. What does it mean to have integrity as a nurse in global healthcare situations? If integrity exists, how can we nurture and fortify it? Integrity is relational and reflective of knowing and doing what is right. Deciding what one should or ought to do is often embedded with potential ethical questions of uncertainty and the risk of conforming—not-conforming with significant others’ desires, wants, and expectations. Contemplating what is right is interdependent and may involve many other people, thoughts, notions, and projects. A common normative ethical term labeled as moral distress arises when there is an inconsistency between one’s beliefs and one’s actions. Webster and Baylis (2000) described moral distress as contexts that include distressful situations where one fails to do the right thing (or fails to do it to one’s satisfaction) for one or more of the following reasons: an error of judgment, some personal failing, or other situations considered by the person to be out of his or her control. Many scholars believe the experience of moral distress may lead to compromised integrity. What is left over from the experience has been labeled as moral residue. The residue may be deeply felt, lasting, painful, and where persons choose to set aside or violate publicly confessed beliefs, values, and principles the residue can sear the heart (Webster & Baylis, 2000).

A Case Study of Moral Residue

Hardingham (2004) described the following situation that happened 16 years before publication of a professional article about integrity and moral residue. She stated that the incident remains ongoing with the pain of moral residue. She described the setting of serving as an administrative coordinator or house supervisor whose responsibilities included rounds of all the units of the hospital in order to make administrative decisions in the absence of nurse managers. She recalled the story of being in the emergency room one night when a patient was brought in after having taken an overdose of medications. The emergency room was short staffed and she went into the trauma room to assist as recorder. The patient was a First Nations woman who was upset and resisting medical care. The patient was found in four-point restraints, cursing the staff. The emergency physician, after demanding several times that she “shut up,” took a washcloth and stuffed it in her mouth to silence her. Hardingham described her feelings as being dumb-founded. She recalled standing there debating whether or not to intervene and remove the cloth as the rest of the team laughed. She described living the moments with a combination of fear, uncertainty, and the feeling that no one else in the room would understand. For Hardingham, the situation led her to question her values. She said, “I resisted doing what I felt was the right thing to do” (p. 129). She handed the record sheet to another nurse and left the room. Hardingham was not alone as the lingering residue continues with questions about her actions, since she stated she knew what the right thing to do was, but did not act or have the courage to do it. Situations such as these happen every day across the globe in healthcare settings. Some may think that this example is an extreme situation, but there are many other examples of practice routines that contribute to what healthcare professionals label as moral distress. As Mitchell (2001) has stated, “it may be the theoretical residue from the objectifying, reductionistic model of healthcare that supports and contributes the creation of routines that dehumanize” (p. 113). May (1996), a philosopher, said that there are three aspects to actions of moral integrity for healthcare professionals including critical thinking, the coherence of value orientation, and the commitment to act in a principled way.

To not act in accordance with one’s values is an unsettling reality of lived value priorities. The conflicting reality is that each nurse expresses values and beliefs through work in hospitals, nursing homes, clinics, and wherever nurses practice. According to Seedhouse (1988), the point is that whatever one does to oneself or another person does not have to be done. There are always alternative possibilities and courses of action available with different consequences. Choosing one action or direction over another, and choosing one policy or procedure over another, can encourage or discourage the meaning of one’s own or another’s existence. The question of one’s existence and its meanings in life and death is a dilemma for family members who participate in healthcare decision-making as well.

The Cost and Anguish With Life and Death: Who Is Accountable?

In a recent editorial from the Los Angeles Times (2008), Mithers described her personal conflicting feelings of obligation and accountability with family members’ healthcare decisions. She described a common scenario of contemporary healthcare where there are no
guidelines for how to manage healthcare when “dying can take a very long time.” With innovation and technology offering new medicines and treatments, persons may be between irreversible declines and at death’s door. She described a medical paradigm for those who are dying that is the same as those who are labeled as healthy. Doctors, out of instinct and training or fear of lawsuits, go all out to fix, fix, fix and intimidate family members to acquiesce. In the newspaper editorial, Mithers described her personal situation of accountability with her 93-year-old widowed father-in-law, diagnosed with Alzheimer’s disease and a small stroke. He was hospitalized for a CT scan, catheterized after the discovery of a mild urinary tract infection and enlarged prostate, then sent to a nursing home for rehabilitation where he promptly injured himself trying to pull out the catheter and was sent back to the hospital. When he returned to the nursing home for the second time, pallor was noticed that led to the discovery of anemia and another hospitalization for a transfusion. More blood was found in his stool which meant a trip to the gastroenterologist. The gastroenterologist announced to Mither’s husband that his father could “live another 5 years” so they ought to consider fixing something that could be repaired. There was no mention of values clarification or mention of advance directives for the patient or the family during these visits. The family was left with the moral residue of accountability and feeling they were obliged to “do all they could do.” She questioned “is another five years of life really what you want to give a demented, wheelchair-bound 93 year old” (p. A23). With millions more elderly across the globe entering into similar circumstances, it is crucial for healthcare professionals to actively engage with questions about what constitutes reasonable medical treatment in the last months or even years of life. Does it make sense for a society drowning in healthcare costs to throw full, expensive technology at people who are not being asked what their wishes or desires are, or have never been made known? Mithers (2008) asked if such medical practices are humane. Are healthcare professionals and professional nurses accountable for the failure to clarify and honor the values of healthcare recipients and their families?

The call in this article is for nurses to reflect on their practice routines and the personal accountability and responsibility to recipients of care. Articulating and acting upon professional values with accountability is essential for the discipline of nursing in order to fortify and enhance its integrity and trust with global communities. Participating in an ethical discussion on these issues is not optional. The discipline of nursing has an ethical obligation and an accountability to humankind to reflect upon issues with straight thinking and coparticipate with other healthcare disciplines in the formation of global health policies and procedures that honor person-family-community health priorities. Each healthcare discipline must question, challenge, and reflect upon its practices in order to hold one another accountable so that the healthcare recipients’ human dignity, freedom, and personal autonomy to choose and make healthcare decisions may be enhanced. Let the discussions begin!

References