

# Responsibility and Accountability, Analyzed

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Careful examination of the structure and function of these concepts leads to a schema that helps clarify some current questions and issues.

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A patient in Oregon recently sued for damages connected with permanent brain damage suffered after surgery on his eyes.<sup>1</sup> As reported in *Regan*, "He claimed he was administered massive overdoses of narcotics and that at the conclusion of surgery he received inadequate amounts of reversal drug and . . . , unnoticed by the hospital's medical and nursing staff, his respiration was substantially depressed. As a result, the amount of oxygen supplied to his brain was reduced and he suffered bilateral brain damage." The latter resulted in the loss of his job and impairment of his driving ability. *Regan* further reports: "The rate and depth of his breathing were not charted despite the fact that the chart provided a place for the recording of respirations."<sup>2</sup>

The court ruled in his favor and awarded \$750,000, stating that "If the recovery room nurses had properly monitored the rate and the depth of the patient's breathing, they would, in the normal course of events, have discovered what was happening and would have had time to give him oxygen so as to prevent brain damage."<sup>3</sup>

While the individual nurses may not have had to pay the actual damages, it is evident from this brief extract that the court regarded these nurses as in some way responsible for the patient's losses, holding them accountable for not having charted the respirations. Nor is this an isolated case; while it is still relatively rare for nurses to be included in malpractice suits, it is an increasing

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phenomenon, as Greenlaw notes.<sup>4</sup> She plausibly attributes the increase to three factors: the changes in nursing education that have brought about expanded nursing roles reflected in contemporary statutory definitions of nursing and in nursing practice; the ongoing effort of nurses to establish nursing as a profession separate from medicine and possessed of its own theory and standards; and the consumerism of the public, as applied to the services of the health care industry.

The question is: How do these three factors relate to the concepts of responsibility and accountability as they have come to be applied to nursing practice under contemporary nursing theory? The changes in nursing education have been brought about in part through the ANA Code for Nurses, which contains two explicit references to responsibility among its 11 points, as well as many additional references to either responsibility or accountability in its interpretative statements. And, as McClure points out, so much has been written about the analysis and application of these concepts that these terms—accountability, in particular—have become virtual bywords for the current era. Nonetheless, she concludes, ". . . when we discuss accountability in nursing in any depth, the clarity of the concept immediately diminishes." She maintains that the problem is not in the definition of the term itself, but rather in the questions: (1) accountability on whose part? (2) for what acts? and (3) to whom?<sup>5</sup>

As a philosopher, I am inclined to think that the analysis of concepts does have potential for clarifying them; and, in the case of accountability and responsibility, I believe that the work of philosophers can be profitably brought to bear in helping to understand both the structure and function of these concepts in nursing. Once

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these dimensions of the concepts are laid out, it becomes easier to answer some of the questions about accountability currently being raised.

#### ASCRPTION OF CAUSAL RESPONSIBILITY

The fundamental purpose of ascriptions of causal responsibility is pragmatic. Scriven has argued that we pick out as *the* cause of some event that one nonredundant member of the set of conditions that must be present for the event to occur.<sup>6</sup> That is to say that while many factors may play a contributory role in bringing about some situation (in that the situation would not have occurred had it not been for the presence of each of those factors), the practical considerations dictated by our particular interests will determine which factor we single out as *the* cause. Baier points out that ascriptions of causal responsibility have the practical function of telling us how "to bring about wanted events and to prevent unwanted events. . . ."<sup>7</sup> Let us apply this insight to the case cited at the beginning of the article.

The patient in that case suggested a number of candidates for the cause of his postoperative complications—among them, massive overdoses of narcotics, inadequate amount of reversal drug, depression of respiration, failure of the hospital and its medical and nursing staff to notice the depression, and failure of the recovery room nurses to chart the rate and depth of his breathing. Of course, his interest was to indicate as many contributing causal factors as would potentially involve liability on the part of the hospital; he did not indicate other contributing factors, such as the circumstances leading up to his need for surgery in the first place, his decision to undergo such surgery, his selection of a surgeon or hospital, or any special sensitivity he might have had to the anesthesia. While these may well have been contributing factors, it was not consonant with his interests to point them out.

The court in such a situation thus has a three-sided task. First, it must determine whether any of the patient's allegations were factual—i.e., whether overdoses of narcotics were in fact administered, whether brain damage occurred, whether the rate and depth of respirations were or were not charted, and so on. Second, the court may also, anticipating the possible allegations of the defense, seek to determine the presence or absence of other potential contributing factors such as whether the patient had a special sensitivity to anesthesia, whether he knew this and had informed the surgeon or anesthesiologist about it, whether brain damage may have preceded the surgery, and so forth. And, finally, the court must select one or more factors to regard as causally responsible for the objectionable condition.

The reason for this last court finding—the ascription of causal responsibility—is pragmatic, although complexly so. Such pinpointing of the causal factors will permit determination of ways in which the hospital might prevent this unwanted outcome in the future; it may permit determination of culpable responsibility for the outcome, or exoneration of all parties from such responsibility; and it may provide a basis for compensation to the patient according to strict liability considerations or as punitive damages. Let us turn to the logic of these pragmatics.

In our case study, the court identified the recovery room nurses' failure to chart the patient's respirations as causally responsible for the brain damage. One might reword this finding to disclose part of its function, as follows: To avoid this type of result, the recovery room nurses should chart respiration rate and depth of all patients who have been given respiration-depressing narcotics as part of the operative or preoperative procedures. That is, one pragmatic aim of the court's ascription of causal responsibility is to indicate an effective point in the chain of events at which a change—i.e., something different done or not done—would have prevented the unwanted event, so that such a change can be instituted to prevent future occurrences.

The court might have reached the same findings—failure to monitor the respirations—even if the chart contained no provision for charting respiration functions, and the community's standard of care did not include charting of respirations. That is, even if there had been no failure to follow established procedure, the court might still have pointed to the absence of respiration monitoring as the cause of the brain damage in order to suggest where, in its opinion, the most effective change could be made to prevent similar incidents in the future. Indeed, it was quite possibly some such judgment made not by a court but by the ANA in setting forth its *Standards of Nursing Practice: Operating Room* that created the practice of charting respiration rate and depth—a practice that the nurses in this case appear not to have followed.<sup>8</sup>

The point to note here, however, is that the logic of the concept of responsibility that has been elucidated up to this point does not yet involve either accountability or responsibility of a sort that entails praise or blame. We will now elaborate on the idea of causal responsibility and its function.

#### ACCOUNTABILITY

Being accountable for doing something involves both *task-responsibility* for doing it and *being held responsible* for doing it by another—what we might call *answer-*

*ability* to someone for it.<sup>8</sup> Not only were the recovery room nurses held to be causally responsible for the brain damage, the court also discovered that they had task-responsibility for charting data about the patient's respiration.

This task might be *assigned*, either institutionally through the procedure manuals setting forth practices for that hospital, or individually by the supervising nurse, the surgeon, or the anesthetist. But, although the task had not been assigned institutionally or individually, it had been assigned by the local community standard of care. It is conceivable, of course, that the recovery room nurses could have *assumed* the task, or even that they could be *saddled* with it by virtue of its being something that needed doing and was not being done by anyone else. But in understanding accountability one must remember that the associated task-responsibility may arise in any of these three general ways. When monitoring respiration became part of these nurses' tasks (whether assumed, assigned, or by virtue of their being saddled with it), they became accountable for that task. Had this case arisen in the absence of any such task-responsibility, then the court's finding of causal responsibility would not have landed the nurses in a context of accountability.

The second aspect of accountability beyond task-responsibility is *being held responsible* for doing the task by someone, *being answerable to* someone for doing it. Correlated with this is that other person's task of supervising the first person, of *holding* him or her responsible when he or she fails in that task-responsibility. Thus, as our recovery room nurses acquired the task of monitoring and charting postoperative respiration rates, they became answerable for doing so to a supervisor; this supervisor thereby acquired the task of supervising them in their task and of holding them responsible in case of their failure to carry it out.

Who that supervisor was is not indicated in the case. Nor is it clear precisely what that task of supervision entails; it may involve only nursing audits of records with follow-up, announced or unannounced site visits and observation, repeated supervisory checking of procedures being followed on a case-by-case basis, or combinations of these.<sup>9</sup>

But the same logic should hold for supervisory tasks as for supervised tasks. Pursuit of wanted events or elimination of unwanted ones leads to assignment of both causal and task-responsibility at the supervisory level, depending on what interests are operative and what appears to be the most cost-effective, most efficient, or

<sup>8</sup>I am employing a slightly altered version of Kurt Baier's excellent analysis (see reference 7).

otherwise most feasible manner for securing those results. The supervisor is himself or herself accountable for task performance to a higher supervisor, who in turn is held accountable for the tasks of the subordinate. This process ends when the limit of interests is reached; the limit may be quite remote or quite close, depending on whether the chain in question is short (say, leading directly to the patient) or long (say, leading to the public through both statutory definition and professional standards).

#### ANSWERABILITY

The supervisor's task-responsibility includes holding the subordinate answerable for a failure to perform the subordinate's tasks. To be held answerable means that one must explain why one has failed to discharge the task. Depending on the explanation, there will be a finding of culpability or of innocence in that failure. For if the individual is to be cleared of culpability, the explanation must be exonerating, exculpating, or at least excusing—that is, it must shift the burden of responsibility for the failure away from the person whose task-responsibility has not been performed. But if there is no explanation or the explanation is not satisfactory, there will be a finding of culpability, which is, roughly, a final location of the sort of responsibility that entails blame for the failure and its consequences. Only after culpability or innocence has been determined is it appropriate to consider rectifying measures.

In our case study, what sorts of explanations might the recovery room nurses have offered that would have shifted the blame away from them? Suppose that the failure to monitor had been due to a direct order from the supervisor, surgeon, or anesthetist not to do so? This might constitute a successful explanation if the order had been properly given and the nurse's level of preparation had been such that physician authority in the matter was appropriate and recognized. It might not constitute successful explanation, however, if the standard of care appropriate to that nurse's practice in light of her preparation would dictate her disputing such an order.

In other words, the nurse's qualifications are relevant to responsibility for failure to perform an assigned task, whatever the explanation for that failure might be. Similar reasoning would apply to the plea of ignorance of the required task: If the nurse's qualifications cover the knowledge and skills needed for that task, then ignorance is not exculpating. On the other hand, if the nurse has been assigned tasks she has not been educated to perform, ignorance might well be a good excuse.

Other types of exculpating explanations might be giv-

en. Another postoperative patient's conditions may have become critical and required a degree of attention incompatible with normal charting procedures, for instance, a pile-up of postoperative patients may have occurred during a period of staff shortage. These and other types of abnormal situations may have occurred in such a way as to excuse the nurses from culpability for failing to maintain adequate charting.

The point of listing such possible explanations is that they pose instructive alternatives to the actual situation and remind us that not only does causal responsibility not necessarily entail accountability, but also that accountability, together with a failure to discharge the task, does not necessarily entail culpability. Furthermore, they emphasize the pragmatic function of assignments of responsibility: that of pointing the way to appropriate means for rectifying the situation that produced the undesirable result or for reinforcing the situation that produced the desired one.

A word of caution is in order. Defenses that are based on the analysis being given must proceed with great care. For example, while a nurse working outside her area of expertise cannot be held to as high a standard of care as a nurse regularly assigned to a unit, this does not imply that no standard of care is applicable. Whether a nurse's plea of ignorance will exonerate must depend in large part on factors falling beyond those involving the content of training—factors which include whether the nurse knowingly accepted a task for which she was inadequately trained, whether the nurse was observant and took care to notify a skilled superior in case of trouble exceeding the nurse's skills, and so forth. As Randall observes, "These (licensing) statutes require an absolute standard of care, and the individual who fails to observe them will be considered negligent."<sup>10</sup>

## RECTIFICATION

If the person held answerable for a particular unwanted occurrence is also found to be culpable, then one range of responses is appropriate: responses directed towards and against the culpable one. If the person is found innocent, then responses directed away from or not against the exonerated one are indicated. In both cases a major pragmatic objective is the prevention of future occurrences of this type (or in the case of a wanted event, the ensuring of future occurrences of the type). But, depending on the supervisor's views on certain complex ethical matters, a second and nonpragmatic objective may be involved: It may be thought that the culpable party *deserves* blame or praise, quite apart from the pragmatic consequences. Let me explain.

A finding of culpability identifies the cause of failure

to perform the task as being within behavior normally believed to be within the individual's control. It then becomes pragmatically desirable to bring about a change in the individual so that he or she will behave in a different way in similar situations in the future. Among the steps that may be taken are a dressing down, an admonition, a reprimand, a warning, some sort of punishment, or even a dismissal. In relation to our recovery room nurses, we might well add such other alternatives as requiring recertification or retraining, shifting the person to another service, and so forth. Note that all these measures focus on the individual found to be causally responsible and are directed toward either changing that individual's behavior or removing the individual from the situation.

By contrast, where the individual is found nonculpable, it would probably not be pragmatically desirable to try to bring about a change in that person's behavior; the exception would be a decision to enlarge, shift, or narrow the individual's task-responsibility so as to achieve a more effective assignment of tasks. Instead, rectifications directed against something other than the individual's behavior may be considered. For example, culpability may be ultimately located elsewhere; some procedure may be altered or a faulty item of equipment repaired or replaced; a test may be replaced or supplemented by a more sensitive one; or some combination of these may be considered.\*

Rectification actions may not, however, be limited to those that are pragmatically advisable; indeed, other types of action may have effects contrary to the pragmatic ones.

A supervisor who thinks that the culpable party deserves blame, for example, may proceed with measures selected not according to their anticipated results, but according to the seriousness of the failure. For example, the supervisor in our case may feel that a strong reprimand or even a warning may be deserved by the recovery room nurses because of their carelessness, even if she doesn't believe that such measures will be productive of behavior change. Or a supervisor may feel that dismissal is warranted for a serious omission, even when the guilt and repentance of the individual already assure that the behavior will be corrected. These kinds of judgment are not pragmatic, and they may result in rectification actions that actually impede the goals of improved care

\*This was the rectification in Arthur Hailey's *The Final Diagnosis* (New York: Doubleday, 1959), in which an indirect Coombs test was added to saline and high protein tests for blood sensitization in Rh negative mothers-to-be; in addition, there was a finding of culpability against the chief pathologist who had opposed adding the indirect Coombs test to the laboratory's standard battery until a newborn fatality occurred for which he was held responsible—that is, where he was unable to provide an exculpatory explanation for his failure to keep the laboratory's tests in line with current developments in his field. Because of a history of other culpable omissions, the rectification included his dismissal.

and safety by creating resentment and exacerbating the attitudes that led to the initial problem.

The foregoing provides a nice illustration of one difference between consequentialist and deontological reasoning, wherein the former aims at producing desired results and the latter aims at providing what is deserved.<sup>11,12</sup>

### THE SCHEMA APPLIED

Let us see how the foregoing schema can be profitably applied to some of the questions nurses ask about nursing accountability and responsibility.

"Are nurses accountable to patients as the American Nurses' Association Code states, to physicians, to the profession, to themselves, to the employing institution, or to the state licensing board?"<sup>13</sup> The imponderability of such questions in this general form may be dispelled by considering one's specific nursing tasks. Questions of accountability for each of those can be answered by determining the following task-responsibility factors:

- (1) What is the task for which you are accountable?
- (2) What is the origin of that task?
- (3) To whom are you answerable for it? Who has the task of supervising your performance in that task and of holding you answerable for any failure in discharging it?

Thus, whether one is accountable to a patient for a particular task might be a function of whether the patient has contracted with the nurse to perform that task or whether it has been assigned by someone else with whom the patient has contracted for services. In the former instance, and if the patient is in sufficiently good health and possessed of sufficient knowledge to determine whether the task is being performed properly or not, the patient would have the task-responsibility of supervising the nurse holding her answerable for any failures in her task-responsibility. This supervisory role, however, may devolve to another if the patient is incapable of proper supervisory functions. It seems to me that, in terms of our analysis, only in the former case should the nurse be regarded as accountable to the patient.

A nurse would be accountable to a physician only when the physician has the task-responsibility of supervising her and holding her answerable. Such a role does not automatically devolve on the physician because he is involved with the patient's case. Such matters will depend upon whether the physician has assigned the task to the nurse, whether she is in his employ or in the employ of an institution in which he has practice privileges, and whether and to whom supervisory functions have been delegated, and so forth.

Where responsibility for licensure and certification has devolved on the state board or the professional organization, then accountability to either of those bodies would seem to involve the nurse's task-responsibilities for acquiring basic and advanced skills. As Creighton points out, "Whereas license is concerned with the minimum qualifications for safe practice in nursing, certification gives recognition to the attainment of specialized knowledge and skills, *i.e.*, quality beyond that necessary for safe practice. Certification by the ANA and other groups is a voluntary plan whereas licensure is mandatory in all except two states."<sup>14,15</sup>

Licensure and certification examinations together with peer review systems serve to establish limits of accountability by establishing the scope of permissible activity for a given nurse. Failure to meet the standards set by these boards and programs usually leads to rectification by restriction of permissible activity and a requirement that additional training be pursued before repeating the examination. But the logic of accountability to state licensure boards and to the profession in these matters appears not to differ fundamentally from that of our schema.

Of course, the fact that one is licensed or certified as one who may properly be assigned or expected to carry out certain task-responsibilities and be held accountable for them does not necessarily mean that all of those will actually be one's task-responsibilities. This determination is generally made by the employing institution. One thereby acquires task-responsibilities by assignment through the nursing administrative structure of the employing institution; similarly, one is accountable for those tasks to that employer indirectly, through direct accountability to one's immediate supervisor. Depending on the size of the institution, immediate supervision will be more or less remote from the employer.

### ACCOUNTABILITY TO SELF

Finally, in what sense are nurses accountable to themselves?

In simply choosing to become a nurse, the nurse assigns herself certain tasks: the acquisition of (a certain degree and range of) nursing skills, the practice of those skills safely and effectively, the development of a set of professional commitments and values. While she may delegate both supervisory and task-responsibility for her acquisition of these to others (e.g., the educational faculty may thus acquire both supervisory power over and accountability to the nursing student), the fact remains that it is the nurse who has assigned herself the task-responsibilities of becoming a nurse; the chain of accountability ultimately stops with her. While others may

at times be properly held accountable for failures of the nurse in her self-appointed tasks of skills acquisition, accountability plus failure does not automatically yield culpability, as we have seen.\* Provided her educators have discharged their task-responsibilities nonculpably, culpability (or, perhaps, only causal responsibility for this task failure) may shift to the nursing student.

Finally the schema may be applied to the question asked by McClure: "In direct patient care, one might ask whether the practicing nurse is to be held accountable only for the care she herself renders, or is her responsibility broader, encompassing all members of the nursing [and, I might add, the health care] team?"<sup>16</sup> Again, this is a general question that may be refocused on specific task-responsibilities, on who has been assigned those tasks, and on who supervises their performance. Does the nurse for instance, have the responsibility for blowing the whistle on incompetent or careless practice by another member of her team(s)? If that is a task-responsibility assigned to the nurse by her professional organization through its code, then in this sense she is accountable (as a kind of supervisor) for the care rendered by others. But if the task is not one which has been assigned, then the nurse would seem to be accountable only if she has herself assumed the task or if she has been saddled with it by circumstances.

#### PROFESSIONALIZATION AND QUALITY CONTROL

The structural and dynamic connections that tie responsibility together and link them to the professionalization goals of nursing now become apparent. In rising to the level of independence required for professional status, nursing has correctly perceived that it is necessary to generate complex structures of task-responsibilities, together with the appropriate educational, licensure, and certification systems to delineate the degree and scope of task-responsibilities and accountability that define professional practice.<sup>17-19</sup> Such delineation permits resolution of potential disputes between professions over such issues as what properly falls within the scope of nursing practice as opposed to that of medical practice. It also permits objective peer review and sets skill and task goals for the individual against which she may measure herself and be measured in determining professional standing.

Accountability and responsibility are thus integrated into a conceptual schema as a structure of formal con-

cepts that figures both in the *constitution* of the content of nursing as a profession and in the self- and societal *regulation* of its practice. As constitutive and regulative concepts, these are among the most important components of modern nursing theory. □

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\*These were some of the issues in *Lyons v. Salve Regina College*, in which a nursing major, having appealed a failing grade and secured a recommendation of a majority of grade appeals committee that it be changed to incomplete, sued the college for breach of contract when the dean refused to accept the recommendation. The court upheld the nursing dean and the faculty who had originally given the failing grade. *Lyons v. Salve Regina College*, 565 F.2d (U.S. Ct. App. 1st Cir. R.I. 1977). Discussed in Creighton, *op. cit.*, Part 2.