research reports

Interpreting accountability

An ethnographic study of practice nurses, accountability and multidisciplinary team decision-making in the context of clinical governance

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Background

Government policy concerned with the modernisation of the National Health Service (NHS) has urged nurses and others working in the health services to become more collaborative, adopt a flexible approach to role boundaries and establish clear lines of accountability for the quality of clinical care. However, the government's clinical governance agenda gives little recognition to the ways in which health care professions have been hierarchically ordered in the past and how these historical relationships may continue to shape multidisciplinary working in the modernised NHS. At the same time, there is little acknowledgement of the ambiguous nature of accountability where role boundaries become blurred. This is particularly the case for nurses. The Nursing and Midwifery Council (2002a), for example, reports that many of the queries they receive and many of the professional conduct cases they hear arise from nurses' uncertainty or lack of awareness about their accountability. Accountability is especially confused in primary care, where modernisation and the need to meet new targets for preventative services have had particular implications for practice nurses. However, the changing role, professional autonomy and accountabilities of practice nurses under clinical governance have been little explored.

The study

This ethnographic study used interviews, vignettes and participant observation to explore how accountability was understood within one team of clinicians working in a general practice, following the introduction of clinical governance. The three main areas of enquiry concerned:

1. how accountability was understood across the health care team;

2. who was involved in multidisciplinary decision-making; and

3. the nature of the relationship between decision-making and accountability.

The practice, which served a patient population of approximately 6,500, was located in a market town in the south of England. It was well established, relatively affluent (a former fund holding practice) and had taken the lead locally in implementing clinical governance. Staff included five partners (three part time), and a part-time retainer, four part-time practice nurses employed by the practice, two attached community nurses, a practice manager, an administrator, six receptionists (full and part time) and two (later four) part-time pharmacy staff.

Fieldwork took place over a six-month period and included participant observation of clinical governance meetings in the primary care team (PCT), multidisciplinary practice meetings and clinical practice. Thirteen semi-structured interviews, which included the use of vignettes to discuss hypothetical clinical situations, were conducted with three general practitioners, four practice nurses, two community staff and four administrative staff.

Findings

1. How accountability was understood across the health care team

The study found that the meaning of 'accountability' was elusive and ambiguous for participants and that this ambiguty mirrored the 'catch-all' use of the term in current government policy. It was described by some as a retrospective explanation of actions, particularly as a way of apportioning or accepting blame. At the same time, accountability could be seen as something that motivates action and good practice and implies a readiness to take the consequences of action. In addition, accountability was used as a way of describing certain relationships, such as those between practitioners and clients, or between employers and employees. In general, participants found it difficult to articulate what accountability meant, and the more intent they became on pinning it down the more its meaning seemed to elude them.

2. Who was involved in multidisciplinary decision-making

It was anticipated that some members of the health care team would be more influential in multidisciplinary decision-making than others, because of the historical relationships between the different disciplines involved.

However, the study found that multidisciplinary decision-making as a contemporaneous collective activity was unusual. In terms of everyday clinical practice, staff tended to make decisions about *individual* patients in isolation. Where such decisions involved different members of the team, they were often made in stages, involving different practitioners at different points. In contrast, decisions about patient *groups* (those concerned with the development of practice protocols, for example) were made by a sample of practitioners from different disciplines working together over a finite period of time. Similarly, decisions about the development of services might involve staff from across the health care professions, but ultimately these decisions were made by the practice partners, who had particular priorities and responsibilities as the owners of a small business.

3. The nature of the relationship between decision-making and accountability

Data from vignettes suggested that, in certain contexts, some practitioners were seen as more accountable than others. For some participants, accountability for clinical decisions rested with those members of the staff considered to have the most expertise, whether or not they were present during decision-making. In some circumstances, and contrary to the legal position, lack of previous contact with a patient, or a poorer grasp of certain kinds of knowledge (for example, where a nurse took on a 'medical' task), were associated with a lesser degree of accountability. Data from across the study suggested that accountability could be passed like a hot potato from one practitioner to another, principally by providing a colleague with a narrative or an account of decision-making. Although some nurses saw themselves as accountable for their practice, a contrasting view was also evident amongst all staff, promoted perhaps by the set-up of the practice as a small business, in which partners were seen to carry ultimate accountability for the decisions made by practice staff. These differing approaches to accountability reflect differences in the stances of regulatory bodies such as the United Kingdom Central Council for Nurses (UKCC)/Nursing and Midwifery Council (NMC) and General Medical Council (GMC).

The study raised unforeseen issues about the accountability of clinicians using such aids to decision-making as practice protocols. Some staff felt that the accountability of practice partners was expanding almost without limit while that of nurses was becoming ever more bounded by the use of protocols. This suggests both the need for greater awareness of policy-makers' understandings of the meanings and scope of accountability and the need for research that looks at the relationship between patient need, nurses' clinical judgement and the knowledge on which more formalised guidance rests. Finally, documentation was seen to have the potential to protect practitioners from litigation but could also leave them open to litigation when it was inadequately completed. Software used to document decision-making placed limits on the information that could be recorded, particularly about nursing practice. Staff felt that meeting patients' needs represented a huge responsibility that they could, to some extent, share with other members of the practice. Yet despite a policy promoting partnership working, for many, accountability for practice remained an individual issue for all clinicians.

Limitations

The findings of the study are limited in that they relate to one general practice and thus provide food for thought rather than generalisable insights. In addition, at the time of research, primary care was entering a period of significant change and, understandably, many practices were reluctant to open themselves to scrutiny during such upheaval. This meant that it took us longer than anticipated to find a research site and, as a result, the fieldwork period was reduced, with less opportunity than planned for observing decision-making over time. Moreover, the requirements of the local ethics committee aimed at protecting patients from feeling pressurised to consent to observation meant that the study included less direct observation of clinical care and decision-making than originally planned. Finally, because of its highly ambiguous nature, questioning participants about accountability was problematic. The research suggests that understandings of accountability can be context-dependent, yet by not being fully aware of this during data collection we may have influenced participants' responses to our questioning. In the use of vignettes, for example, we asked who was accountable in a certain scenario and, by our style of questioning, may have prompted participants to think more about accountability as blame, rather than giving them scope to draw on the term's other meanings.

Recommendations

✦ Ambiguity in the literature and the clinical area about the nature and extent of the accountability of different professional groups jointly involved in decision-making highlights the need for a joint statement of clarification from the main regulatory bodies.

✦ Findings from this ethnographic study suggest that multidisciplinary decision-making may be limited in the primary care context because of lack of opportunity for colleagues to meet collectively and because of the constraints placed on collective decision-making within general practices as small businesses. A broader study based on survey and multiple case studies is therefore proposed to further explore the nature, extent and implications of multidisciplinary decision-making in primary care.

✦ The study identifies the importance of protocols for practice nurses who are working at the boundaries of existing nursing roles, but also highlights concerns about the status of the knowledge on which these protocols are based, and about the relationship between these tools and practitioners' clinical judgement. This suggests the need for further research to explore the way in which GP practice protocols are developed and maintained, and to investigate the relationship between protocols, clinical judgement and accountability.

✦ The lack of practitioner clarity about professional and legal accountability in a changing health service suggests the need for continuing professional development in this area. The study indicates that it would be useful to develop such resources as workshops or videos that use different clinical decision-making scenarios to explore and improve practitioners' understanding of their accountability in different contexts.

1. Introduction

The Westminster White Paper, *The New NHS: Modern, Dependable* (DoH 1997) proposed a statutory duty for chief executives of health care organisations to implement systems of clinical governance to ensure good-quality care. A number of factors contributed to the introduction of clinical governance, such as raised expectations on the part of patients and changes in care delivery systems. However, the most notable factors in the context of this policy proposal were declining public confidence in the NHS and a rise in the number of complaints going to litigation (McSherry and Pearce 2002).

Clinical governance, first referred to in 1997 (DoH 1997), has been summarised as a system or systems that minimise risk and monitor clinical quality throughout an organisation (McSherry and Pearce 2002). These systems are underpinned by a drive towards increased collaborative working matched by increased emphasis on individual accountability (Garland 1998; McSherry and Pearce 2002).

Clinical governance provides considerable challenges for nurses. Along with other associated policy initiatives, clinical governance places great emphasis on evidence-based medicine (EBM) in which 'evidence', at least until very recently, has been drawn almost exclusively from the basic sciences of medicine (Sackett 1997) and focuses primarily on the care of populations (Tonelli 1998). Clinical governance and its emphasis on EBM would therefore seem to present a dilemma for nurses who prioritise individualised care or who may value forms of knowledge specific to nursing (see, for example, Benner and Wrubel 1989) that are generally given less weight than medical knowledge. Moreover, it seems that the multidisciplinary working heralded by clinical governance may rest on decision-making predominantly shaped by the knowledge of the most powerful disciplines.

Clinical governance is also of concern to nurses because of the way it has prompted a blurring or redrawing of boundaries (Smith 1998) and encouraged collaborative working while seeking to ensure optimal organisational performance on quality through emphasising individual accountability and professional self-regulation (DoH 1997, 1998; NHS Executive 1999). This has led to considerable confusion about the nature and extent of practitioners' accountability. The Nursing and Midwifery Council (NMC) (2002a), for example, reports that many of the queries they receive from nurses relate to uncertainty about accountability, and many professional conduct cases are the result of nurses, midwives or health visitors not fully appreciating their accountability. The complex nature of accountability (see, for example, contributors to Watson 1995a) and the legal confusion regarding accountability where the nursing/medical boundary has become blurred (Tingle 1997) have been largely overlooked in the clinical governance literature.

One area where accountability is particularly confused is in the field of primary care, especially with reference to the position of practice nurses. Recent NHS reforms have focused on primary care as part of the modernisation process, increasing responsibility and accountability at local level. This affects practice nurses in particular because of, among other things:

✦ the requirements of clinical governance and its emphasis on multidisciplinary working and the blurring of roles;

✦ the nature of practice nurses' employment, with many employed directly by general practitioners whose priorities are shaped to some degree by their status as small business owners;

✦ an absence of strong lines of professional management for primary care nurses;

✦ the growing involvement of practice nurses in the attainment of government targets set for certain procedures in primary care, which can attract income for the practice.

1.1 The study

Using an ethnographic approach, this study represents an initial exploration of the ways in which accountability is understood in the context of clinical governance and multidisciplinary decision-making. It focuses on one multidisciplinary team working in a primary care setting and concentrates in particular on the accountability of practice nurses.

The study aims to:

✦ understand how the concept of accountability is understood among different members of the team;

✦ establish the way in which the relationship between decision-making and accountability is viewed;

✦ identify who is involved in decision-making within the interdisciplinary team;

✦ explore who is seen as accountable by members of the multidisciplinary team in specific situations.

1.2 Background

The main areas discussed here are the concept of clinical governance; accountability with particular reference to nursing and multidisciplinary working; and the position of practice nurses.

1.2.1 Clinical governance

Clinical governance has been described as a policy initiative resulting from 'the need to reduce inappropriate care and to reduce inefficient and inequitable variations in the quality of health care' (Bloor and Maynard 1998: 4). It can be understood as a framework for a range of activities that fall into three key areas: quality improvement, risk management/management of performance, and systems for accountability and responsibility (RCN 1998). However, clinical governance has received a mixed response from health care professionals (Miller 2002) and there is still widespread confusion about this initiative. According to Scott (1999: 173), for example, '[w]e have been given a jigsaw without a picture'. In a definition described by Maynard (1999: 198) as 'practically useless', the Department of Health suggests that clinical governance is:

> a framework through which the NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care can flourish.
>
> (DoH 1998)

For Smith (1998), this definition makes no reference to clinical governance as the outcome of protracted attempts to align clinical, ethical and fiscal priorities. Others suggest that the quality of health care provision

that clinical governance seeks to improve tends to be narrowly conceived in terms of clinical effectiveness and cost-effective care (see Bloor and Maynard 1998, for example), with little emphasis on experiential aspects of care or patient involvement in decision-making. A sceptical view of clinical governance is that it is a system for ensuring managerial control of clinical practitioners by building clinical practice around quality assurance (Charlton 2001). Clinical governance can also be understood as a response to a crisis of public trust and yet, as O'Neill (2002: 99) pointed out in the BBC Reith Lectures:

> We may constantly seek to make others trustworthy, but some of the regimes of accountability and transparency developed across the last 15 years may damage rather than reinforce trustworthiness.

Smith (1998) suggests there are two systems according to which clinical governance can develop:

a) a corporatist approach which favours directing the implementation of policy and monitoring of outcomes from the centre, with a political link running from the Health Secretary through to chairs in trusts and health authorities; and

b) a collaborative governance system – in which corporate goals are agreed with stakeholders. In this system of shared leadership, while the centre sets targets and monitors performance, there is none the less room for manoeuvre and the delivery of broader corporate goals. As typified by shared governance, adherence to principles of transparency, open communication and public accountability are assumed to encourage the participation of stakeholders.

According to some (for example, Scott 1999), introducing clinical governance requires a process-oriented rather than a function-oriented organisation. This means that, in terms of structure, the organisation needs to be flat, decentralised or team-oriented, and to draw on consensus. There is an emphasis on vision and strategy, rather than short-term thinking, while communication is essentially horizontal but can also flow from bottom to top as well as top to bottom. Staff have a broad range of competencies and produce 'customer-focused' rather than standardised outcomes (Kennerfalk and Klefsjo 1995).

One feature of process-oriented health care organisations, however, is the risk that patients travel

through the system horizontally, being passed from one professional to another, with 'no one professional who understands or is accountable for the process of care the patient experiences, or indeed the outcome of that process' (Scott 1999: 171). This risk might be reduced by good teamwork and less rigid professional boundaries, both of which are integral features of clinical governance. However, there is a lack of clarity about the nature of the teams involved and whether, for example, they are to be multi-professional, multidisciplinary or inter-professional in nature: the government tends to use these terms interchangeably in its documents (Scholes and Vaughan 2002).[1]

Ambiguity about the nature of the clinical team raises particular concerns for nurses, not only because their professional identity may be undermined where they are expected to take on the knowledge and skills of other groups but also because of the complex and ill-defined nature of their accountability.

1.2.2 Accountability and nursing

Accountability has long been a complex issue for nurses, particularly since the introduction of the nursing process, an initiative that has both clarified and recast the nature of nursing and nurses' accountability (McFarlane 1980). Significantly, the nursing process has been credited with transforming nursing from the simple carrying out of tasks to a process of decision-making informed by specialist knowledge, whilst also allowing the evaluation of individual practitioners (Reed 1992).

These and other, broader, trends in health care reform such as the purchaser–provider split, which partly aimed to ensure greater explicitness and transparency in decision-making, have heightened pressure on nurses to become more accountable (Watson 1995b: 2). At the same time, accepting accountability can be seen as part of a professionalising strategy for nursing (see, for example, the UKCC's *The Scope of Professional Practice*, 1992b): being able to claim accountability is what sets professions apart from other kinds of occupations (Watson 1995b).

McFarlane noted as early as 1980 that the introduction of the nursing process heralded not only the need to review the accountability within clinical nursing, but also to review 'the role of nursing decision-making vis-a-vis medical decision-making' (1980: 6). More recently the RCN (1990) considered the location of accountability within the nurse/doctor relationship and raised an issue that is also relevant to interdisciplinary collaboration under clinical governance. According to the RCN paper (1990: 8):

> in the application of knowledge and skill, based on scientific training and qualification, the knowledge base of medicine encompasses, to a significant degree, the knowledge base of nursing.

In other words, in terms of knowledge, the medical profession has traditionally had something of a monopoly. This raises an important question: although nursing has a complementary knowledge base, where does accountability for nursing practice lie, given the dominance of medical knowledge in the interrelationship of medicine and nursing?

Along with *The Code of Professional Practice* (UKCC 1992a), which outlined the extent of the individual nurse's accountability, *The Scope of Professional Practice* (UKCC 1992b) has been seen as one of the most significant documents for the practice of modern nursing (Jones 1996). It recognises that nurses' practice was previously constrained by the acceptance of extended roles shaped by doctors, in which nurses' competence was assured by certification. *The Scope of Professional Practice* therefore sought to provide nurses with the authority to expand their role as they saw fit, on the understanding that they first assure themselves of their competence and that they accept full responsibility and accountability for the whole of their practice. As such, this document has enormous significance for the professionalisation of nursing.

1.2.3 Accountability and multidisciplinary working

There remains great confusion about accountability in practice, particularly in the context of expanded and

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1 In the context of health care services, words with the prefix 'multi' suggest collaboration amongst different professional groups, without the implication of any change in roles, skills, knowledge or line management and, consequently, a system of parallel decision-making. Alternatively, the prefix 'inter' implies some change in roles, knowledge, skills and responsibilities to adapt to those of other team members (Payne 2000).

extended roles, where nurses enter into new relationships with other members of the health care team. In fact, the guidance offered to the nursing profession in *The Scope of Professional Practice* (or 'the Scope' as it is commonly known) is at odds with the British Medical Association's stance in *Protecting Patient Safety* (BMA 1996), which provided guidelines on 'medical' procedures performed by non-medical staff. Similarly, regulations arising from the GMC and the UKCC are at times contradictory and hard to interpret, with the UKCC's (1992b) document assuming 'a degree of nursing autonomy and power not reflected in the medical guidelines' (Tingle 1997: 1011) (see Section 2.5.2 for further discussion of this area).

This raises a particular dilemma for nursing in the context of clinical governance. Clinical governance is not solely a medical issue but requires successful interaction between a range of clinicians, including those allied to medicine: 'If it is captured by the medical profession and perceived by others as "doctor driven" it is likely to be ineffective' (Bloor and Maynard 1998: 7). The Department of Health (1998) has stipulated that a designated senior clinician is identified by each trust for ensuring that systems for implementing and monitoring clinical governance are in place. However, it is already clear from guidance on clinical governance from the Central Consultants and Specialists Committee of the British Medical Association that the medical profession, at least, expects it to be medical consultants taking the lead role as senior clinicians (British Medical Journal 1999).

Indications of professional dominance exist in the field of primary care, where a study of the early experiences of nurses on English primary care group (PCG) boards indicated that nurses considered they had little influence and that PCG decision-making was dominated by GPs (Dowswell, Wilkin and Banks-Smith 2002). Similarly, a study of appointments to 59 PCG boards found that practice nurses were recruited by a different method to other members such as GPs, namely via nomination and election, and that they were generally underrepresented as a group (Smith et al. 2000). At the practice level, research on collaborative working between GPs and district nurses found that, while all study participants espoused an idealised view of mutually respectful collaborative working relationships, nurses were aware that GPs tended to dominate the decision-making process (Rowe 1999). These different inputs into decision-making are not unrelated to the GPs' status as independent contractors

and purchasers of services. However, if this trend continues, clinical governance may serve to perpetuate the traditional relationship between medicine and nursing while *appearing* to blur traditional professional boundaries and promote a model of individual accountability compatible with the requirements set out by nursing's regulatory body. This point is particularly relevant for practice nurses.

1.2.4 The position of practice nurses

The number of practice nurses in England has roughly trebled over the past 15 years, with some working as nurse practitioners, some undertaking a triage role and others joining integrated teams with district nurses and health visitors (Waller 2000). This increase is linked to a number of factors. It reflects, for example, the dissatisfaction of nurses who moved from other areas of practice, or who sought more sociable hours of work (Atkin and Lunt 1995; Stillwell 1991). The increased numbers of practice nurses is also associated with the introduction of the GP contract in 1990, which offered GPs remuneration for meeting targets in immunisation, cervical smears and health promotion (Jones 1996). In addition, it marks a response to the range of policy initiatives that have given priority to disease prevention and health promotion, and have aimed to make primary care the cornerstone of the NHS (Atkin and Hirst 1994). Finally, it reflects government pressure to improve cost-effectiveness in the primary care sector, with a move from more- to less-expensive care providers. The White Paper *The New NHS: Modern, Dependable* (DoH 1997) built on previous strategies for a primary-care-led NHS, with a view to developing locally accountable, integrated local health care systems. One of the key strands of this approach was introduction of primary care groups (PCGs) which were later to evolve into primary care trusts (PCTs). PCTs are supposed to become the lead organisation in the planning and delivery of health care, but research suggests that they have a major capacity problem, with insufficient staff either to deal with everyday functioning or to implement the modernisation agenda (Bosma and Higgins 2002). The recent increase in practice nurse numbers reflects the shortage of GPs and the problems that PCTs are experiencing in recruiting an appropriately trained and skilled workforce (Williams and Sibbald 1999; Wilkin et al. 2001).

Researchers have found that practice nurses and GPs believe practice nursing to have improved the range and accessibility of services offered to patients, helped the practice meet its targets and prevented unnecessary use of GPs' time (Atkin and Lunt 1995). However, despite the increasingly important contribution that practice nurses make within general practice, there is widespread uncertainty about the role (Bowling 1980; Atkin and Hirst 1994), partly because its nature cannot be divorced from the need for the practice nurse to generate income. Alongside new targets, an increased policy focus on disease prevention and health promotion has meant a lack of distinction between the roles of practice nurses, district nurses and health visitors (Williams and Sibbald 1999). Some practice nurses work without job descriptions (Patterson 1993) and, at least historically, have had insufficient input into developing the protocols guiding their practice (Stillwell 1991).

Significantly, most practice nurses (98 per cent in 1994) are employed by GPs and this unique relationship has a number of implications. First, the appointment of a practice nurse reduces the take-home pay of their employer unless the nurse can generate income. At the same time, few practices could achieve target payments for cervical smears or immunisations without the involvement of practice nurses (Atkin and Hirst 1994; Bowling 1988).

Second, the new roles undertaken by practice nurses, shaped by the needs of individual GP practices, have developed in an ad hoc way, often in advance of approval from professional bodies. This has led to the kind of scenario described by Jones (1996: 3), who found that 'Almost overnight, newly employed practice nurses were expected to become experts in childhood immunisations and health promotion'. Practice nurses can therefore be acutely vulnerable, especially as, according to current law, a practice nurse is expected to provide patient care to the standard of an ordinary skilled practice nurse, even on her first day in post (Martin 1996). Atkin and Lunt (1995) found that many practice nurses were convinced of the need for induction courses, given the contrast between practice nursing and other forms of nursing roles. The GP-employed practice nurse, working outside the mainstream of nursing, is less likely to be legally protected than a nurse employed by a health authority or trust (Bowling 1988). In 1980, a study by Bowling highlighted the fact that nurses who were delegated tasks by general practitioners were confused over their

legal position, and there is little to suggest that this picture has changed. Many practice nurses now employed by general practitioners are without the support of a nursing line manager and may undertake a wider range of duties than those in other employment structures (Bowling 1988). This may lead to a tension between practice nurses' professional allegiance and allegiance to their place of work (Williams and Sibbald 1999).

Third, the demands of individual GP practices have led to a considerable heterogeneity within the role of the practice nurse. One study of practice nurses, for example, found that there was no particular type of work that was consistently regarded by practice nurses as outside their role (Atkin and Lunt 1995). In line with this finding, a study by Noakes and Johnson (1999) found that the role of the practice nurse varied from one practice to another; that practice nurses required no specific qualification; and that the levels of qualification and experience of practice nurses varied widely. They state that 'a shortage of experienced practice nurses has led to practices employing nurses with an acute or community background and organising training on an individual basis to suit the needs of the nurse and the practice' (Noakes and Johnson 1999: 22).

Mackereth (1995) found that practice nurses carried out a wide range of tasks that fell into three broad groups: practical tasks (such as ear syringing, taking blood samples), screening (for example, ECG tracing, taking cervical smears), and disease prevention or health promotion (see Appendix 1 for Mackereth's full list of tasks). In contrast to previous studies that suggested the increasing importance of technical screening tasks, Mackereth found considerable variation in the range of such tasks, suggesting a lack of role definition.

Widespread variation in practice also includes different degrees of autonomy for nurses. Dimond (1991), for example, highlights the way that in some practices a GP may advise a patient on travel medication, write a prescription and ask a practice nurse to administer it, while in other practices nurses identify and administer the appropriate travel medication for patients. Increased autonomy has generally been matched by an increased variety of standards and protocols. Mackereth (1995), for example, suggests that written protocols have become a way of clarifying the role of the practice nurse, with most of the nurses studied working to more than five protocols, in line with national figures.

Fourth, with the exception of prescribing, there have

been few legal constraints on the nurse's role, but traditionally there has been little funding available to train practice nurses in either traditional or extended roles (Bowling 1988). In 1988 Bowling identified that either practice nurses or their employing GPs paid training fees, in the absence of any grant funding. More recently, the transfer of purchasing power to GPs means that they increasingly control the work, training and assessment of practice nurses (Venning and Roland 1995; Jones 1996). However, as small employers, general practitioners do not always have the resources to encourage the training and support of practice nurses (Atkin and Hirst 1994), and training for new tasks can be ad hoc (Mackereth 1995). Moreover, research suggests that even in situations where practice nurses face few restrictions on training opportunities, there is generally an absence of formal appraisal schemes to identity training needs (Atkin and Lunt 1995).

Fifth, research suggests that most GPs employ a practice nurse primarily to meet their responsibilities for providing general medical services (Atkin and Lunt 1995). The nature of practice nurses' employment (that is, as GPs' employees), together with the way that their role is shaped by the requirement of GPs, has led to concerns that practice nurses work according to a medical model rather than a more holistic, nursing one (Mackereth 1995). Evidence suggests that GPs appear to have little understanding of either the nature or scope of a nurse's professional responsibility (Atkin and Lunt 1995).

Finally, the nature of their employment and their concentration on screening procedures has meant that practice nurses tend to work alone, with limited supervision (Mackereth 1995). Atkin and Lunt (1995) found that practice nurse supervision was given little attention. In a postal survey of all practice nurses in Gateshead, Mackereth (1995) found that 16.1 per cent worked alone. This gives some support to earlier studies that suggested isolation was a key problem for practice nurses, although Mackereth suggests that working alone does not in itself suggest isolation. However, she notes that even in practices with more than one nurse there may be little opportunity to meet with other practice nurses because of the hours worked.

In summary, employment outside the usual NHS (including nursing management) structure, alongside the potential isolation of the practice nurse, the need to generate income, confusion about the role and the range of skills required, and poor access to training all contribute to making practice nurses a particularly vulnerable occupational group.

1.3 Summary

Changes in health service policy mean that nurses and others working in the health services are encouraged to become more collaborative with colleagues, adopt a flexible approach to role boundaries and accept increased scrutiny. Clinical governance is a good example of this, with its emphasis on 'clear lines of responsibility and accountability for the overall quality of clinical care' (NHS Executive 1999). However, the government's clinical governance agenda gives little recognition to the ways in which health care professions have been hierarchically ordered in the past and how these historical relationships may continue to shape multidisciplinary working in the modernised NHS. Moreover, despite policy emphasis on the need for health care professionals to respond flexibly to the needs of the new NHS, and to be prepared to be accountable for their practice, there is little acknowledgement of the ambiguous nature of accountability where role boundaries are becoming blurred. The position of the practice nurse offers a particularly cogent example of changing roles and working relationships under clinical governance, and of the shifting accountabilities that may accompany these.

2. Review of the literature

2.1 Introduction

The concept of accountability is not new: public expectation of the need for auditing of official expenditure, one form of accountability, was evident in Athens as long ago as 400 BC (Bergman 1981). However, the concept of accountability has evolved over the years from a matter of regular reporting to an explanation of actions and outcomes and, more recently, a justification of the values informing actions and outcomes (Bergman 1981).

The term 'accountability' is used with increasing frequency in management and policy discourse, and yet it seems as if its meaning is becoming more and more vague, or that the same term is used to describe an increasing number of phenomena. This state of affairs has been neatly described by Hunt (1994) as a reversal of the story about a group of blindfolded people feeling an elephant. In the traditional story, people feeling different parts of the animal develop diverse ideas about the object before them. In the case of accountability, Hunt suggests, everyone thinks they have hold of an elephant when in fact they are feeling a number of different beasts.

In this review we outline the ways in which accountability has become central to NHS policy and practice before exploring different lines of accountability and different meanings attributed to accountability within the NHS and the health care professions. The relationship of accountability to other terms, such as 'responsibility' and 'authority', is also considered. The chapter goes on to explore the position of nursing's regulatory body on accountability, particularly in relation to new roles in nursing, and the implications of the new emphasis on accountability for nursing practice. Finally, the chapter briefly sets out legal aspects of accountability.

2.2 Accountability and the NHS

The New NHS: Modern, Dependable (DoH 1997) outlined a set of values and practices, namely those of decentralisation, partnership, flexibility, self-regulation, empowerment and individual accountability, consistent with new-wave management. Clinical governance, a less centralised form of regulation involving more direct supervision of clinical practice, was first described in *A First Class Service* (DoH 1998). This outlined the five overlapping themes of clinical governance: national consistency in quality and access to care; accountability for quality; quality improvement and assurance; the management of poor performance; and collaborative working.

Individual clinicians were previously charged with providing care of sufficiently high quality. With clinical governance, this obligation was extended. A system of monitoring and improving the quality of health care was to be achieved through devolving authority to those closest to the provision of clinical care, a move to multidisciplinary decision-making and new professional partnerships at a local level . Significantly, regulation was to be augmented by the scrutiny of peers: 'the central aim of clinical governance is to hold groups of professionals accountable for each other's performance' (Allen 2000: 608). In this way, accountability has become central to the modernisation of the NHS.

2.2.1 Research on accountability

If accountability has emerged as one of the dominant themes of the 1990s and one of the driving forces behind the modernisation of the NHS (DoH 1997), there is little research concerning understandings or implications of accountability, or about accountability in practice. This is despite the fact that literature based on survey and opinion has highlighted accountability as a complex and controversial concept for clinicians working within health care organisations (Walsh 2000; Watson 1995b; Ferlie et al. 1996).

For the most part, existing research was undertaken before the introduction of clinical governance and it tended to consider managers' perceptions of accountability and where it is due. Day and Klein (1987), for example, found that the majority of health authority members in their study felt that they were

most accountable to patients or the local community ('downwards accountability'). In contrast, Ferlie et al.'s (1996) study of perceptions of accountability held by NHS board members indicated a stronger sense of upwards accountability and, most notably, accountability to the individual who appointed them, despite the rhetoric of devolved management. Board members seemed to have little sense of accountability to their staff, although they did consider themselves accountable to their professional colleges. This posed dilemmas for senior medical staff undertaking the role of medical director in NHS trusts, as they could find their managerial and professional responsibilities in conflict. What was common to findings from both studies was that participants used 'accountability' in a variety of senses, demonstrating the confusion and contradictions inherent in the term.

2.3 Defining accountability

This section looks at the way accountability has been defined in the broader context of health care literature and presents the research undertaken in this field before going on to consider understandings of accountability specifically in the nursing literature. Accountability is also looked at in relation to other terms, such as 'responsibility' and 'authority', to further understand the meanings of the concept.

2.3 1 Definitions of accountability in the health care context

According to Tingle (1995: 167), the various definitions of accountability that exist are starting-points only: 'Defining accountability does seem to be an almost tautological exercise – the concept is a broad one which is, arguably, indefinable'. Accountability has been described by health policy analysts as an ambiguous concept that is open to multiple interpretations (Mander 1995; Ferlie et al. 1996) and NHS policy documents concerning modernisation make frequent reference to accountability without providing explicit definitions of what is meant by the term.

'Accountability' is a term of many nuances. Bergman (1981), for example, suggests that it can mean both to be 'counted on' (in the sense of being dependable) and 'being able to be counted' (that is, being ready to speak

out against injustice or bad practice). However, in order to pin down the meaning attributed to the term in any particular context it might be helpful to look at its association with other terms. Accountability is often teamed with 'open', for example, as in the phrase 'open and accountable', suggesting that accountability is associated with visibility or transparency.

A First Class Service (DoH 1998: 3.12) implies that accountability is largely achieved through reporting systems and ways of monitoring quality, suggesting that the term is best understood in terms of outcome. For example, it is stated in *A First Class Service* that, through national comparative clinical audit, doctors will be able to compare their own performance with national averages. Individual doctors will be required to share their results with the medical director of their trust and the clinical lead responsible for clinical governance. In addition, doctors from the Commission for Health Improvement will have access to these data when they review local standards and clinical governance processes. Accountability would therefore seem to be understood as the practice of making the detail of local and individual practice visible, and accepting judgement on this practice in terms of whether, or to what extent, it conforms with nationally developed standards. This suggests that, although modernisation initiatives such as clinical governance are ostensibly founded on the principle that health care professionals must be responsible and accountable for their own practice (DoH 1998: 3.43), accountability is largely about compliance with externally agreed criteria rather than being fundamentally rooted in the practitioner's clinical judgement.

This tension between external standards and an individual practitioner's judgement is also evident in the opinion/instructional literature on accountability. McSherry and Pearce (2002), for example, state that accountability for health care professionals is concerned with changing practice – that to be truly accountable, practitioners need to ensure that their practice is evidence-based, efficient and effective. Little or no reference is made to other important elements of health care practice, such as compassion or respect for privacy or diversity, that cannot be judged against the yardsticks of efficiency or effectiveness but which are none the less central to professional codes of conduct (see, for example, NMC 2002b).

Lewis and Batey (1982) make a helpful distinction between structural accountability (represented by the pattern of disclosures) and accountability as an

internalised predisposition (the willingness to assume responsibility for the outcomes of professional actions) or a critical attribute of the practitioner, with ethical as well as legal dimensions. They argue that, in contrast to accountability understood as a structural variable, 'the state of being accountable is instead a perceptual predisposition towards feeling accountable. This perceptual state may be independent of the actual organisational realities' (1982: 10).

2.3.2 Definitions of accountability in the nursing context

An analysis of accountability based on an extensive review of the theoretical literature and interviews with directors of nursing carried out by Batey and Lewis (Batey and Lewis 1982; Lewis and Batey 1982) has informed much of the thinking on nursing accountability, most notably McFarlane's position (see Section 1.2.2). They provide the following definition of accountability as:

> The fulfilment of a formal obligation to disclose to referent others the purposes, principles, procedures, relationships, results, income and expenditures for which one has authority. This disclosure is systematic, periodic, and carried out in consistent form. Disclosure occurs so that decisions and evaluations can be made and reckoning carried out. As a formal obligation, accountability is an institutional requirement expected of one participating in an organisation. It is not based on the peculiar whims of individual personalities but instead on official mandates and positional requirements of the agency.
>
> (Lewis and Batey 1982: 10)

This emphasis on accountability as disclosure governed by official mandates is mirrored by Dowling et al. (1996), who provide a definition of accountability in terms of the obligations and liabilities arising from:

✦ professional regulations (for example, those set out by the General Medical Council (GMC) or UKCC – now NMC);

✦ the law on civil wrongs (torts) to patients;

✦ employment law relating to the relationship between employers and employees.

Some writers make it explicit that nurses' accountability concerns not only accounting for actions but also being answerable for them (for example, Pennels 1997; Kershaw 1998; Walsh 1997; Jones 1996). Other definitions within the nursing literature suggest that accountability is the requirement of each nurse to be able to give an account of his or her actions, but without necessarily accounting to formal bodies. For example, the UKCC (1996: 8) defines accountability as being:

> fundamentally concerned with weighing up the interests of patients and clients in complex situations, using professional knowledge, judgement and skills to make a decision and enabling you to account for the decision made.

For Duff (1995: 50), 'to be accountable denotes an acceptance of the obligation to disclose and the possible consequences of disclosure'. Disclosure involves making decisions explicit so that others can evaluate them, and such disclosure may be discretionary in that the timing and extent of disclosure may depend on the situation and the other people involved. These 'other people' may include patients/consumers, colleagues, regulatory bodies or employing organisations (Duff 1995), to whom accountability is owed, irrespective of disclosure. This interpretation of accountability suggests that it exists as a potential, as something that may be made real only in particular circumstances.

2.3.3. Types of accountability

In addition to the different aspects of accountability identified above, some analysts have identified different kinds of accountability. Leat (1988), for example, suggests that accountability has different dimensions in the health care context. These include:

✦ fiscal accountability (concerning financial probity and the ability to trace and adequately explain expenditure);

✦ process accountability (concerning the use of proper procedures: for example, demonstrating that locally derived standards and those set out by National Service Frameworks are being adhered to);

✦ programme accountability (concerning the activities undertaken and their quality); and

+ priorities accountability (concerning the relevance or appropriateness of chosen activities).

Of these, she suggests that process and programme accountabilities are the most relevant to clinical governance.

Eby (2000) suggests that in addition to the accountability found within institutions (financial and public accountability), the individual operates through four dimensions of accountability:

+ *Social accountability*, which sets norms for acceptable behaviour within society, relying on the individual offering or being asked to provide accounts that explain their actions in an attempt to shape the way others will perceive these.

+ *Ethical accountability* relating to the moral obligation to be answerable. This is derived from the relationship of implicit trust between client and practitioner. This dimension of accountability stresses values and principles identified with various ethical approaches as follows:

    + duty based: focusing on the duty of health care professionals to be accountable;

    + consequences-based: focusing not on the explanation or the individual but on the consequences of an account;

    + virtue-based: focusing on the integrity of the accountable individual with implict faith in that person's knowledge of what is the right explanation to give;

    + principle-based: assuming that truth and honesty are the fundamental principles on which to base an account

    + emotive: possibly focusing on the fear surrounding accountability.

According to Eby, the impact of these different ethical approaches to accountability influences both the nature of an individual's explanation and the response to that account.

+ *Legal accountability*, since being accountable is enshrined by law through acts of Parliament, case law, tribunals and inquiries.

+ *Professional accountability*, which is associated with individuals recognising that they are members of a profession and therefore accepting the status, rights and responsibilities that attend this. This ethos of accountability is articulated in the UKCC's *Guidelines for Professional Practice*, which suggests that: 'Accountability is an integral part of professional practice, as in the course of practice you have to make judgements in a wide variety of circumstances' (UKCC 1996: 8).

According to the UKCC, professional accountability rests on the two interrelated concepts of ability and competence. Ability is understood as the relevant knowledge skills and values to make decisions and act upon them (the requirement to update knowledge and skills is enshrined in professional codes of practice). Competence is described as the ability to perform a responsibility with appropriate knowledge and skill, and to perform that responsibility in terms of appropriate scope and quality.

Each profession is accountable to its statutory body, such as the General Medical Council or the Nursing and Midwifery Council (NMC, previously the UKCC). Decisions about a member's continuing registration depend on the *quality* of the accountability and responsibility involved. Rather differently, Bergman (1981) suggests that there are *degrees* of accountability and that in some contexts, a nurse may have no accountability, minimal accountability, good accountability or full accountability. She argues that accountability is dependent on certain preconditions: that the nurse has ability (appropriate knowledge, skills and values) as well as appropriate responsibility and authority. In some of the literature, however, these preconditions appear to be confused with accountability itself, as the following section demonstrates.

2.3.4 Accountability in relation to other terms

One of the problems with the term 'accountability' is that it conveys little meaning in itself. In particular, it has been widely recognised that accountability cannot be considered in isolation from other terms, such as 'autonomy', 'responsibility' and 'authority' (Lewis and Batey 1982; Dewar 1999; Walsh 2000; Pennels 1997). All these terms are relevant to the carrying out of a charge, such as an act of nursing for which someone (individual or organisation) is answerable. Significantly, 'charge' can be defined as 'to load heavily or burden', 'to place a bearing upon', or it can refer to 'that which is laid on',

such as care or custody (*Chambers 20th Century Dictionary* 1972). In work that continues to be seminal in this area, Batey and Lewis (1982) help to demonstrate the way in which certain terms overlap with accountability by defining them. Responsibility, they suggest, is 'a charge for which one is answerable' (p. 14); authority is 'the rightful power to act on the charge' (p. 14); and autonomy is 'freedom to decide and to act' (p. 15).

2.3.4.1 Responsibility

Dictionary definitions suggest only minor areas in which the meanings of accountability and responsibility overlap. The Shorter Oxford English Dictionary (1978), for example, defines 'accountable' as 'liable to be called to account; responsible (to, for) … to be counted on … to be computed … explicable'. In contrast, 'to be responsible' is to be 'morally accountable for one's actions; capable of rational conduct … answerable to a charge … capable of fulfilling an obligation or trust, reliable, trustworthy, of good credit or repute'.

However, much of the health care literature on accountability equates the term with responsibility (Batey and Lewis 1982; McFarlane 1987; Eby 2000). In the glossary of the Nursing and Midwifery Council's *Code of Professional Conduct* (NMC 2002b), for example, accountability is defined as being 'responsible for something or someone'. In in the US context, Lewis and Batey (1982) found that accountability was understood both as an acceptance of a nurse's obligation to disclose what he or she has done (and of the consequences of disclosure) and as the condition of being responsible for acts performed as a professional. Their research amongst Directors of Nursing in the US found that many thought the words accountability and responsibility were synonymous (Lewis and Batey 1982).

Often, responsibility has been understood as the main component or precondition of accountability. Eby (2000: 190), for example, suggests that 'it is the acceptance of a course of action as well as the acceptance that an individual should be willing to give an account for the nature and conduct of that task'. Similarly, Tschudin (1992: 111) proposes that accountability is a continuous process of monitoring one's professional conduct and that one is 'constantly responsible and therefore constantly accountable'. According to Batey and Lewis

(1982: 14), with responsibility, 'the focus is on the charge, not on how or to whom the answering would or should occur'. They also hold that responsibility is distinct from being responsible, the latter suggesting a personal characteristic – namely the willingness to accept a charge.

From a health care perspective, Walsh (1997) suggests that a clear distinction should be made between accountability and responsibility in nursing practice. He proposes that accountability involves explaining and justifying actions based on sound professional knowledge and transparent, logical and replicable decision-making. Conversely he believes that responsibility, in the traditional sense, means performing tasks in an accurate and timely way through delegation. Accountabililty, therefore, is viewed as being on a higher plain in that it requires independent thought.

According to Dewar (1999: 27), who considers responsibility and accountability in the context of clinical governance, 'responsibility suggests an immediate relationship within your organisation' in contrast to accountability, which suggests 'a wider relationship with the organisation, the wider system or the public'.

2.3.4.2 Autonomy

Autonomy is attributed a number of meanings in the nursing literature, including self-determination, self-direction, the freedom to interact on an independent level with other professionals, and being left on one's own to work (Batey and Lewis 1982; Mander 1995; Duff 1995; Eby 2000). In a concept analysis, Keenan (1999: 561) provides an operational definition of autonomy as 'the exercise of considered, independent judgement to effect a desirable outcome' and suggests that accountability is a consequence of autonomy.

Again, work-related autonomy has attitudinal and structural components:

> Structural autonomy exists when professional people are expected to use their judgement to determine the provision of client services in the context of their work. Attitudinal autonomy exists for people who believe themselves to be free to exercise judgement in decision-making.
>
> (Hall 1968: 53)

As a result of synthesising the meanings and conditions of autonomy, Batey and Lewis (1982: 15) arrive at a definition of autonomy as 'freedom to make discretionary and binding decisions consistent with one's scope of practice and freedom to act on those decisions'. They note a close relationship between autonomy and certain forms of authority, particularly positional authority and the authority associated with expert knowledge (see below).

2.3.4.3 Authority

Authority can be understood as the legitimate power to fulfil a charge or responsibility (Batey and Lewis 1982). According to Batey and Lewis (1982), authority in nursing derives from a number of sources including authority of the situation (as in emergency situations), of expert knowledge (as granted through professional registration) and of position (where authority is invested in a formal position rather than an individual). These authors argue that authority and responsibility are seen as prerequisites of autonomy and accountability and therefore an individual who lacks authority of position or knowledge cannot be accountable. In contrast, others suggest that accountability and authority are interdependent in that a greater degree of accountability is expected of those with greater authority (Pennels 1997).

It has been observed that there can be no meaningful discussion of accountability without consideration of the power relations that shape practice (Orr 1995). According to Dewar (1999: 26):

> To make someone accountable requires power. There are at least two dimensions to power: one dimension is 'explicit' power, which enables actions that can further or harm an individual's career, remuneration or professional status. The other dimension is 'implicit' power such as the ability to use profession, status or personality to resist or complement explicit power. Power is usually drawn from a mixture of explicit and implicit factors.

He suggests that 'authority' is an appropriate term for describing the power that underpins accountability. Authority, he argues, will determine whether accountability is legitimate, whether those who are accountable have the capacity to act or the ability to share accountability with others.

Responsibility, autonomy and authority are important terms, not only in the way they overlap with the concept of or exist as preconditions for accountability. They are also relevant for understanding lines of accountability.

2.4. Lines of accountability

In clinical governance, accountability exists as both a lateral system of answerability to colleagues and as (often new) vertical lines of accountability. Professional traditions of standard-setting and self-regulation are now matched by a further system involving health authorities, NHS regional offices, the Commission for Health Improvement (CHI), primary care groups (PCGs) or trusts (PCTs) and the Secretary of State, who can act where performance is not satisfactory (Shapiro 1998). The relationship between these vertical and lateral accountability mechanisms is not spelt out, but as Shapiro (1998: 296) puts it 'at the heart of the Darwinian, evolutionary rhetoric lies the potential for Stalinist centralisation'.

This nexus of accountability has been described by Hunt (1994) in terms of:

✦ upward accountability ('looking up the line and doing what the managers and administrators require' (p.134);

✦ lateral accountability (accountability as self-regulation, in which practitioners are accountable to, and judged by, criteria set by their peers); and

✦ downward or public accountability (where NHS staff are accountable to patients).

Allen (2000) makes similar kinds of distinctions but includes a practitioner's accountability to his or her professional organisation and to the broader community in which they are located (a 'downward' accountability).

Similarly Dewar (1999) maps lines of accountability within the NHS, but in doing so implies that the nature of accountability may vary, depending on context and who individuals or organisations are accountable to. He identifies three lines of accountability as follows:

✦ An administrative line in which organisations are accountable to the government (which in turn is accountable to the public via general elections). Within organisations, lines of accountability can

be traced from chief executive to clinical teams and individual practitioners.

✦ A professional line, in which clinicians are accountable to the organisations that regulate their profession.

✦ An inspection line, between government and independent inspectors such as the Commission for Health Improvement (CHI).

Significantly, Dewar (1999: 33) suggests that, while lines of accountability between NHS trusts and other bodies are relatively clearly mapped out by policy, the impact of policy is less clear within trusts. According to Dewar (1999), one of the key aims of government is to design a system for generating authoritative guidance and translating such guidance into practice. Establishing accountability for change is central to this approach. However, questions concerning who is accountable to whom, and for what, remain unanswered. In *The New NHS: Modern, Dependable* the Department of Health (1997) intended that chief executives of trusts would become accountable for the overall quality of health care provision by giving them a statutory duty to ensure the framework for clinical governance is in place. Beyond this, however, at the level of the clinical team, for example, there is no increase in explicit power to help with the implementation of policy. As Dewar (1999: 33) puts it: 'the closer we get to the sharing of accountability between clinicians and managers within a trust, the less specific policy becomes'. This same point might also be made with regard to the sharing of accountability between members of the clinical team.

Davies (2001: 63) has highlighted two forms of accountability that have relevance for the practitioner working in multi-professional teams. The first form of 'calling to account';

> Invokes notions of superiors (managerial or political) demanding 'proof of performance' from subordinates, on the basis of which sanctions will be wielded: the meritorious shall be enriched and the non-meritorious shall have exhortation and punishment.

In this scenario, accountability is understood as hierarchical and quantitative in nature. Its focus on individuals and their shortcomings directs attention away from more systemic failings of health care organisations and makes it difficult to understand day-to-day accountability because of the contingent nature

of care. In contrast, according to Davies, accountability can be conceptualised as horizontal, wherein individual practitioners are seen as part of a strong network of professionals delivering team-based care by sharing a range of competencies. In this context, characterised by shared care, learning and expectations, 'the individual is accountable (qualitatively and quantitatively) day-by-day in real time to many other stakeholders' (Davies 2001: 63).

Simply demanding accountability, a characteristic of much of the policy literature, does not, in itself, say anything about to whom an individual is accountable, or who has the right to hold others to account. It leaves unanswered the limits of accountability and the criteria by which an individual can be called to account. Moreover, it glosses over whether the accountability referred to is that of an individual, a group or an institution (Hunt 1994; McSherry and Pearce 2002).

2.4.1 Nursing and lines of accountability

Accountability seems particularly complex for nurses, largely because of the historical relationship between nursing and medicine, and nursing's ambiguous status as a profession (Walby and Greenwell 1994; Davies 1995). Nurses face particular challenges with clinical governance in which decision-making may continue to be shaped by the most powerful groups, despite the espousal of new multidisciplinary partnerships. As Duff (1995) suggests, equality is central to the successful implementation of quality initiatives and accountability. The government has emphasised the new clinical and leadership opportunities available to nurses within the new NHS (DoH 1997). However, nurses' effectiveness as team players can be undermined by the blurring of medical and nursing roles, a lack of managerial and educational support and the legal confusion regarding extended roles (Dowling et al.1996; Naish 1997; Tingle 1997). It is also suggested that nurses face potential conflict between the public accountability expected of them from their professional organisation (NMC) and upwards accountability to their employing organisation.

Darley (1996), a professional officer at the UKCC (now NMC), suggests that many nurses are confused about who they are accountable to. He suggests that accountability can be personal, employer-related or professional in nature. Personal accountability refers to

how the practitioner is expected to act, including the responsibility of a nurse to use his or her professional judgement to practise safely in the interests of patients. In addition, Darley suggests that nurses are accountable to both their employer and to the NMC but for different reasons. Employee accountability relates to duties carried out for the employing organisation and may involve sanction (such as termination of employment) if a practitioner has not met his or her contractual obligations. In contrast, accountability to the NMC relates to the practitioner's professional obligations. Thus a nurse might lose her job but her case would be referred to the NMC only if it appeared that she had breached the Code of Professional Conduct.

Conflicting lines of accountability is a particular problem for practice nurses. Nurses in primary care have been encouraged to accept formal leadership positions within primary care groups and trusts, to influence decision-making at the local level and to contribute to the development of health care for their community, using their existing professional networks (RCN 1999). As part of the modernisation programme, practice nurses are encouraged to take on new nursing roles, such as greater involvement in disease management within primary care (DoH 1997). What these changes suggest about their accountability is not always clear.

2.5 Nursing and accountability

It is only relatively recently that accountability has become a complex issue for nursing. When the General Nursing Council (GNC) was first established, all its decisions were subject to the approval by the Minister for Health and both Houses of Parliament. This meant that any attempt by the GNC to raise educational standards that was deemed by the government to be too expensive was overturned. Consequently, nursing was modelled on an apprentice system that stressed obedience and the importance of following orders (McGann 1995). Although nurses were legally accountable from 1919 with the passing of the Nurses Registration Acts, for much of the twentieth century nursing had few, if any, of the features of a profession and therefore the professional accountability of individual practitioners was less tangible (McGann 1995).

According to Walsh (2000), professional accountability was first introduced to nursing with the publication of

the UKCC *Code of Professional Conduct* (see Section 2.5.1). However, there was lengthy consideration of nurses' accountability before this, as part of the agenda to professionalise nursing heralded by the Nurses, Midwives and Health Visitors Act of 1979. At a seminar for Fellows of the RCN at Leeds Castle (RCN 1980), Jean (now Baroness) McFarlane argued that, in the past, doctors often adopted a managerial role towards nurses, deciding on the duties that they would perform. Under this regime, nurses were considered answerable to doctors, and had little individual accountability. However, with the development of clinical nursing through such initiatives as the nursing process, primary nursing and individualised care, the traditional relationship between medicine and nursing began to be challenged.

What was distinctive about the nursing process was that it offered nurses a tool for analysing patient need and planning their care:

> The nursing process was a decision-making process, that is, decisions about the nature of nursing interventions, and the evaluation of nursing actions were made on the basis of information. At each stage of the process decisions were made – what data was needed on which to base an assessment? What inferences could be drawn from the data? What were the patient problems? What nursing actions would alleviate those problems? How could these nursing actions be organised with the resources available? How could a nurse determine whether the action was efficient or effective?
>
> (RCN 1980: 6)

McFarlane (RCN 1980) argued that clinical nursing practice, where it involved this kind of decision-making, and if it was carried out with any degree of competence, demanded a broader range and higher order of skills than those associated with simply carrying out tasks. With the introduction of the nursing process, therefore, there was a need to review both the nature of accountability in clinical nursing and the relation of nursing decision-making to medical decision-making.

Significantly, McFarlane also suggested that the recognition of nurses' accountability posed questions about relationships between nurses themselves. For example, she argued (possibly ahead of her time) against a hierarchy of clinical posts with line relationships, on the basis that this would suggest a

hierarchy of accountability that would detract from the accountability of the practitioner providing individual patient care. Later McFarlane (1987: 50) developed her argument by saying that accountability 'implies decision-making about nursing care based on sound knowledge and the ability to evaluate the care given from a basis of established standards and criteria'. She also made an important statement that predates the shift towards multidisciplinary decision-making by saying:

> Enabling the clinical nurse to be responsible relates very closely to the way in which we organise nursing care. If it is organised along the lines of task assignment and routines and procedures, the nurse cannot take responsibility for her [sic] charge, she has no professional authority, she cannot take discretionary decisions and act on them, she cannot be accountable. Only if the nurse is involved in informed decision-making about patient care which is planned and implemented on an individualised basis can she be held accountable.

> (McFarlane 1987: 51)

This link between individualised care and accountability is significant. Although poorly defined, individualised care is not only about the assessment of individual patient need but also provides a means of auditing the practice of individual practitioners (Reed 1992). Through the documentation of the nursing process or care plans, it offers a way of specifying quality and cost (ibid.) and identifying the contributions and omissions of specific practitioners. As such, along with similar initiatives such as the 'named nurse', individualised care potentially redefines the professional nature of nursing in line with a general trend towards individualism (Salvage 1985), and underscores the accountability of individual practitioners in relation to that of their employing authority (Savage 1995). This is despite the fact that the provision of care is often a collective activity and finding discrete areas for which individual nurses can be held solely accountable is difficult (Latimer 2000).

While there are those who argue that clinical audit is a key to accountability – that nurses cannot be accountable unless there are unambiguous standards and outcomes against which performance can be measured (Duff 1995) – others suggest that accountability cannot be understood simply in terms of

the extent to which a practitioner has adhered to procedure or 'covered themselves' by ensuring there is documentation to turn to when something goes wrong (Hunt 1994, 1997). Instead accountability has to involve the exercise of professional judgement:

> Professionalism cannot be reduced to the strict observance of procedures or rules of accountability. It is certainly a mark of professionalism that behaviour is constrained and guided by procedures and rules of accountability… but it is quite wrong to conclude that the more observant one is, the more *professional* one is. It is also quite wrong to conclude that the more one constrains professional activity with procedures and rules the *better* (more effective, safer, satisfying, happier or whatever) the practice, such as nursing, necessarily is.

> (Hunt 1997: 522)

Hunt (1994: 131) suggests that recent reference to accountability is part of a more general absorption of nursing into a more technical-rational understanding of health and health care provision, characterised by the use of techniques and instruments such as audit and quality assurance. In other words, accountability is 'tied up with the increasing technicalisation of care'. This stands in contrast to an understanding of nursing accountability as 'moral responsibility narrowed down by the role of the nurse' (Hunt 1994: 133), or a personal code of conduct that implies having to answer to oneself, therefore denoting a level of personal accountability or 'self-accountability' (Tingle 1995).

2.5.1 Accountability and nursing's professional bodies

Until the inauguration of the Nursing and Midwifery Council (NMC) in 2002, the United Kingdom Central Council (UKCC) had been the professional regulatory body for nurses, midwives and health visitors that set standards for education, training and the professional conduct of registered practitioners. The UKCC was established by the Nurses, Midwives and Health Visitors Act of 1979 in order to set and maintain standards of training and conduct for the profession. Its first edition of the *The Code of Professional Conduct* (UKCC 1992a), published in 1983, for example, endorsed the

primacy of the interests of the patient or client and set out the principles governing practice that may be used for judging standards of practice if a practitioner is called to account. The Code, however, despite a series of advisory documents that attempted to clarify its meaning, prompted some confusion amongst practitioners. Some of the most confusing clauses were those that required each nurse, midwife and health visitor, 'in the exercise of professional accountability', to:

✦ work in a collaborative and co-operative manner with other health care professionals and recognise and respect their particular contributions within the health care team (Clause 5);

✦ have regard to the environment of care and its physical, psychological and social effects on patients/clients, and also to the adequacy of resources, and make known to appropriate persons or authorities any circumstances which could place patients/clients in jeopardy or which militate against safe standards of practice (Clause 10); and

✦ have regard to the workload of and the pressures on professional colleagues and subordinates and take appropriate action if these are seen to be such as to constitute abuse of the individual practitioner and/or to jeopardise safe standards of practice (Clause 11).

In response to this confusion, the UKCC published *Exercising Accountability* (UKCC 1989), which spelt out that, although the Code only referred to 'accountable' and 'accountability' once, these terms provided the central focus of the Code, and noted that:

> Accountability is an integral part of professional practice, since, in the course of practice, the practitioner has to make judgements in a wide variety of circumstances and be answerable for those judgements.

> (UKCC 1989: 6)

In *Exercising Accountability*, the UKCC reiterated that the first theme of the Code was the primacy of the interests of the patient. However, it clarified that the second major theme was 'the exercise by each practitioner of personal professional accountability in such a manner as to respect the primacy of those interests' (UKCC 1989: 7).

The document *specifically* refers to the practitioner's accountability in a number of contexts:

1   *With regard to the environment of care*
It recognised that in many clinical situations, there can be a tension between the maintenance of standards and the availability of resources, but stipulated that poor standards cannot be tolerated. Where practitioners accept a position of compromise, they contravene the interests of patients 'and thus renege on personal professional accountability' (1989: 7). Instead, where practitioners are concerned that lack of resources or other conditions prevent them from meeting satisfactory standards, they need – 'as an expression of their personal professional accountability' (1989: 9) – to express their concerns and, crucially, where patients have not been given the care they require, to make contemporaneous and accurate records.

2.   *With regard to consent and truth*
The document states that practitioners have a duty to provide information to patients about their condition – information that allows them to give informed consent. This may lead to a conflict between the principle of truth telling and the capacity of the patient to cope with the truth. However, 'accountability can never be exercised by ignoring the rights and interests of the patient or client' (UKCC 1989: 11).

3.   *Advocacy on behalf of patients or clients*
The UKCC stated that the exercise of professional accountability 'involves the practitioner in assisting the patient by making such representation on his [sic] behalf as he would make himself if he were able' (1989: 13).

For a summary of the above, see Figure 1.

In addition, and of particular relevance to this study, *Exercising Accountability* refers to the importance of collaboration across the health care team. However, it has nothing to say about nurses' accountability in this context other than stating that, in many situations, the care of patients and clients is a shared responsibility. In 1996, however, the UKCC brought out its guidance *Guidelines for Professional Practice* which included the statement that 'No-one else can answer for you and it is no defence to say that you were acting on someone else's orders' (UKCC 1996: 8).

Guidelines for Professional Practice (UKCC 1996) also provided guidance on all 16 clauses of a new *Code of Professional Conduct* (UKCC 1992a) and starts with

a consideration of accountability entitled 'Accountability – answering for your actions'. It also states that 'Professional accountability is fundamentally concerned with weighing up the interests of patients and clients in complex situations, using professional knowledge, judgement and skills to make a decision and enabling you to account for the decision made' (UKCC 1996: 8).

Also of relevance to multidisciplinary working, *Guidelines for Records and Record Keeping* (UKCC 1998) reminded nurses of the importance of recording their actions and omissions. It notes, for example, that their legal and professional duty of care means that they must provide a full written account of their assessment, plan of care and provision of care. In addition, nurses are also professionally accountable for ensuring that any duties, including record keeping, delegated to members of the inter-professional health care team who are not registered practitioners, are undertaken to a reasonable standard. It states that the nurse must countersign any records made by those they delegate to and are professionally accountable for the consequences of such an entry. Moreover, 'The approach to record keeping which the courts of law adopt tends to be that "if it is not recorded, it has not been done"' (UKCC 1998: 10).

The UKCC's *Scope of Professional Practice* (UKCC 1992b) drew on the principles described in the new *Code of Professional Conduct* (1992a) and *Exercising Accountability* (UKCC 1989) to guide nurses' professional practice when taking on new roles. As such, it replaced previous Department of Health guidance on what can be carried out by a nurse, midwife or health visitor. As Darley (1996:17) points

out, the Scope does not give practitioners freedom to do whatever they want, nor does it allow them to refuse additional duties. Instead it stipulates that practitioners should only take on activities beyond their usual role if they believe that they are adequately prepared, where they have the necessary competency and knowledge and where there are sufficient resources to allow safe practice.

2.5.2 Expanded/extended roles

Significantly, *The Scope of Professional Practice* appeared at the same time that the hours of junior doctors were reduced by the New Deal. The Scope made it possible for nurses to take on tasks that were generally understood as 'medical', according to their capabilities and skills. This competence-based system replaced a previous locally based system of certification, often overseen by doctors. However, even post-Scope, some confusion remained about whether doctors should continue to ensure nurses' competence in quasi-medical areas, and about the accountability of the nurse where they had extended their work into the medical arena (Finlay 2000). For example, a letter to the *British Medical Journal* in 1997 points out that the extension of vicarious liability on the part of trusts to indemnify nurses carrying out tasks traditionally done by doctors had yet to be tested. There was therefore 'an urgent need for a mechanism of accountability, both to the patient and to the professions, which should be developed jointly' (Lombard et al. 1997: 1833).

Figure 1 – Summary of the principles against which to exercise accountability (UKCC 1989)

1	The interests of the patient or client are paramount.
2	Professional accountability must be exercised in such a manner as to ensure that the primacy of the interests of patients is respected and must not be overridden by those of the professions or their practitioners.
3	The exercise of accountability requires the practitioner to seek to achieve and maintain high standards.
4	Advocacy on behalf of patients or clients is an essential feature of the exercise of accountability by a professional practitioner.
5	The role of other persons in the delivery of health care to patients or clients must be recognised and respected, provided that the first principle above is honoured.
6	Public trust and confidence in the profession is dependent on its practitioners being seen to exercise their accountability responsibly.
7	Each registered nurse, midwife or health visitor must be able to justify any action or decision not to act taken in the course of her [sic] professional practice.

More recently, the UKCC (and subsequently the NMC) has supported developments within the modernisation of the NHS that have placed nurses at the centre of care delivery, such as NHS Direct. In response to enquiries about whether or how nurses' accountability is affected by working in these new care settings, it has been stated that those on the professional register need effective induction and training programmes before they are able to take professional accountability for this type of practice (Knape 1999). They must ensure that they evaluate the outcomes of these programmes and that they are able to practice in accordance with the best interests of their patients. The principles of the *Code of Conduct* and *The Scope of Professional Practice* apply equally to practitioners in these new areas of work as to any other practitioner. Significantly, Knape (1999: 1514) suggests that nurse-led services such as NHS Direct :

> provide opportunities for registered practitioners not only to take control of the delivery of care, but also to shape the very structure and scope of the services themselves. It is the responsibility of individual practitioners to ensure that they are confident and competent to be able to deliver the service in the safest and most effective way which serves the interest patients and clients.

In 2002, after the fieldwork period of this study, the new Nursing and Midwifery Council produced a revised *Code of Professional Conduct* (NMC 2002b) for nurses, midwives and health visitors. This aimed to 'inform the professions of the standard of professional conduct required of them in the exercise of their professional accountability' (2002b: 3). It sets out the same professional standards as the former UKCC Code (1992a) but also provides explanatory notes and, where relevant, legal advice to supplement these. In addition it incorporates guidance previously set out in *The Scope of Professional Practice* (UKCC 1992b) and *Guidelines for Professional Practice* (UKCC 1996), in response to practitioners who requested that the different publications were combined. In future, further to legal advice received by the UKCC, it will include advice on indemnity insurance, in line with other health regulatory bodies (NMC 2002b).

The NMC Code suggests that being accountable is being 'responsible for something or to someone' (2002b: 10). Specific references to accountability are surprisingly scant and are as follows:

> You are personally accountable for your practice. This means that you are answerable for your

actions and omissions, regardless of advice or directions from another professional.

> (1.3)

> You are personally accountable for ensuring that you promote and protect the interests and dignity of patients and clients, irrespective of gender, age, race, ability, sexuality, economic status, lifestyle, culture and religious or political beliefs.

> (2.2)

However, most relevant to the current study, (and in contrast to previous UKCC documents which did not make any specific reference to accountability in the context of teamwork), the new Code states that:

> When working as a member of a team, you remain accountable for your professional conduct, any care you provide, and any omission on your part.

> (4.5)

and

> You may be expected to delegate care delivery to others who are not registered nurses or midwives … You remain accountable for the appropriateness of delegation, for ensuring that the person who does the work is able to do it and that adequate supervision or support is provided.

> (4.6)

2.5.3 Accountability in practice

As mentioned earlier, there are few studies of accountability in clinical practice. One exception is a study by Annandale (1996), who found that nursing and midwifery are increasingly marked by risk due to the impact both of patient consumerism and the individual accountability placed on nurses and midwives by employing organisations. In a study based on a survey of trained nurses and midwives employed in one hospital trust, and in-depth interviews with nurses working within the neurology services of a second trust, Annandale found what she called ' a climate of risk'. Nurses and midwives reported that they had to be constantly vigilant in the light of the risks posed by practice in the current climate. For instance, they practised defensively, resorting to excessive documentation of their activities that took time away from their priority of providing direct patient care. Nurses and midwives stated that they were often pressurised into taking on tasks without the necessary

competence, and felt that, increasingly, errors and inaccuracies rebounded on the individual practitioner. The situation was compounded by the absence of nursing line management and the introduction of a general management structure in which there was a lack of familiarity with clinical concerns. Annandale (1996) notes that these practitioners' concerns were not entirely new but link to longstanding debates about the professionalisation of nursing and midwifery, the nature of nursing and midwifery knowledge and practitioners' accountability. What was new was the changing context in which nurses and midwives practised, marked by an individualistic ethos in which patients became consumers who generated risk, and in which individual accountability was stressed.

Similar findings emerged in a study of residential care of older people in the US. Weiner and Kayser-Jones (1989) found that the nature of state regulation of nursing homes resulted in a range of what they call 'defensive practices'. These included an inappropriate reliance on medical help at all hours and a heavy emphasis on record keeping and maintenance of the physical environment rather than on the quality of patient care. As they put it, 'the need for accountability has diverted attention away from therapeutic work … in the service of defensive work' (1989: 38).

In a study of changing clinical roles amongst hospital-based doctors and nurses, Dowling et al. (1996) found that accountability for the scope of new roles taken on by nurses following the reduction of junior doctors' hours – and the standards of practice that apply to these roles – remained unclear. They suggested that many nurses may saw *The Scope of Professional Practice* as a watershed in defining the nurse–doctor relationship, removing nurses' dependence on doctors for the assessment of their competence to take on tasks previously been

defined as medical (see Rumsey 1997, for example).

However, Dowling et al. (1996) suggest that redrawing the nursing/medicine boundary may mean that experienced clinicians (both nurses and consultants) become vulnerable to complaints or legal action, especially where there is little guidance on accountability should things go wrong. To illustrate this point they provide a fictional case report – a composite example of issues observed during the study – describing a new nursing role created by a medical consultant and approved by a hospital trust to fill the gap resulting from the absence of a pre-registration house officer. An experienced nurse was given three weeks to shadow a house officer and learn specific skills to allow her to carry out routine work. She was accountable, both clinically and managerially, to the consultant and, through him, to the medical director. Despite the advice of senior nursing staff, nurses were not involved in the planning or management of the post. This example highlighted the complexity and contradictory nature of accountability for nurses who are simultaneously:

✦ managerially and clinically accountable to the consultant/trust;

✦ professionally accountable to the UKCC;

✦ individually accountable to the patient.

This fictional case study illustrated that, without appropriate support, nurses in new roles face potential conflict, may be under pressure from the medical staff to carry out tasks they do not feel competent to fulfil and risk both breaking professional UKCC regulations and breaching a duty of care to the patient.

The recommendations from the study are set out in Figure 2.

Figure 2 – Recommendations to minimise risk with new roles that blur the nursing/medicine boundary (Dowling et al. 1996)

✦ Nurses and doctors should be equal partners in the planning, management and training for these new clinical roles.
✦ Patients should be informed adequately of the postholder's role and relevant training.
✦ Changes in the work of such postholders should be formally acknowledge by the employer and relevant insurers.
✦ Staff should have access to legal advice and support.
✦ The GMC, UKCC and NHS Executive should work together to ensure relevant regulations of the scope and standards of new professional roles.

2.5.4 Legal accountability

Practitioners' legal accountability is a complex area and one that cannot be considered in detail here. Briefly, there are four areas of legal accountability relevant to the practitioner:

✦ accountability to the public under criminal law;

✦ accountability to the profession through Professional Conduct Committee of the UKCC;

✦ accountability to the patient in civil law for negligence, trespass and other civil wrongs;

✦ accountability to the employer through the contract of employment, enforced in civil courts and industrial tribunals (Andrews 1995).

Like everyone else, nurses have a legal duty of care to others and, in their professional capacity, to act with reasonable care towards a patient. This duty of care is breached where the practitioner fails to follow accepted professional practice without reasonable grounds. While what may count as acceptable practice is defined by the profession, it none the less remains subject to endorsement by the courts. Employers may also define the standard governing their employee's performance in relation to their job description. Provided the nurse works within established terms of employment and protocols, their employer will be legally responsible for their actions (vicarious liability). Alternatively, where there is negligence on the part of the employee, both employer and employee will be legally accountable (Tingle 1995).

Employers have a responsibility to ensure that the person in post is competent and they may be directly liable if staff are placed in situations in which they are not competent to function. Nevertheless this does not detract from a nurse's professional accountability to acknowledge the limitations of her competence. Where a nurse feels unable to carry out certain duties in a safe and competent manner, these duties should be declined if the nurse is to discharge the requirements of accountability (Glover 1999a).

If nurses do not keep up to date with the knowledge they need for practice, they will be accountable if a case of negligence is brought against them. They are not expected to keep abreast of all areas of practice, but are required to be familiar with developments in their own area of practice or those developments in other areas that may affect their own practice. In the case of litigation, the court decides on what would be a

reasonable action in a specific situation by applying what is known as the Bolam test. Arising from case law relating initially to doctors, the principles of the Bolam test are that:

> A man need not possess the highest expert skill at the risk of being found negligent … it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.

> (Bolam v Friern Barnet Hospital Management Committee 1957)

This test has now been extended to all health care professionals, to help establish the standard of performance that can be expected of the ordinary, skilled practitioner.

Nurses' legal accountability is of particular importance in a number of ways for this study. First, nurses are expected to become involved in multidisciplinary teams, and yet the law does not recognise a concept of team liability. All qualified individuals within a team are accountable for their acts and omissions, and practitioners cannot use the claim that they acted on the directions of others as a defence against negligence (Glover 1999b). Second, practice nurses are vulnerable where they work outside a nursing management framework and without a clear job description. Finally, the work of practice nurses varies from one practice to another but generally extends beyond traditional nursing activities. Despite the introduction of *The Scope of Professional Practice*, there is some dissonance between medical and nursing understandings about who decides on whether or not nurses accept new responsibilities, for example tasks that were previously understood as medical. An extended role also raises issues about access to appropriate training. Significantly, accountability has to be considered in relation to a recognised standard of care comparable with that performed by the ordinary, competent person exercising that particular art. In other words, being inexperienced is no defence for providing an inferior standard of care (Furlong and Glover 1998). Legally speaking, the standard of care expected from practice nurses is that associated with the role and not the person carrying out the role. Thus, in areas of work previously carried out by doctors, the standard of care required is that of a doctor (Tingle 1998).

2.6 Summary

Accountability has become central to the modernisation of the NHS yet there has been little research since the introduction of clinical governance on understandings or implications of practitioners' accountability. Historically, the literature suggests that accountability has been attributed with multiple meanings and that there have been multiple attempts to impose order on these – to map out types and lines of accountability, for example – but that accountability remains resistant to such efforts. Arguably, nurses have wrestled with accountability more than any other health care group once nursing seized accountability as an emblem of its professional status. At the same time, the meaning of accountability has changed. It has become increasingly associated with audit and the technicalisation of care, rather than, say, moral responsibility. Nursing's regulatory body has led the march towards nurses' 'personal accountability' – an accountability perhaps more concerned with government agendas and the needs of the NHS (for example, the implications of the New Deal) than with moral responsibility.

With the blurring of professional boundaries and the multidisciplinary working promoted by clinical governance there is now uncertainty about where accountability lies and, as a result, research evidence of defensive practice. At the same time, legal understandings of accountability do not closely correspond with the accountability of clinical governance. Overall the literature suggests a need for better understanding of the nature of practitioners' accountability in the context of traditional professional understandings of accountability and the requirements of clinical governance.

3. Methods and methodology

This section of the report offers a justification of the study's methodological approach and provides a description of the different methods employed. It also explains how access was gained to the field and outlines the nature of fieldwork. Finally, this chapter outlines the ethical issues raised by the study and how these were addressed.

3.1 Aims of the study

This study represented an initial exploration of the ways in which accountability was understood in the context of clinical governance and multidisciplinary decision-making, focusing on one multidisciplinary team working in a primary care setting. To reiterate, the aims of the study were to:

✦ understand how the concept of accountability is understood among different members of the multidisciplinary team;

✦ establish ways in which the relationship between decision-making and accountability is viewed;

✦ identify who is involved in decision-making within the multidisciplinary team;

✦ explore who is seen as accountable by members of the multidisciplinary team in a specific situation.

3.2 The choice of ethnography

An ethnographic approach was chosen for a number of reasons. We wished to explore in depth aspects of health care practice in the context of a single setting, a general practice surgery. We wanted to elucidate the emic perspectives of practitioners in the surgery (Hammersley 1990) and to describe rather than change existing practice.

Ethnography represents an attempt to understand a local world and the social reality of a particular group. Ethnographic research is generally characterised by a number of features. Generally speaking, ethnography:

- is carried out in everyday settings;

- allows the use of a range of methods to capture data arising from different perspectives;

- evolves with respect to design throughout the study;

- focuses on the meanings of individuals' actions and explanations, rather than their quantification;

- emphasises the importance of context in understanding events and meanings; and

- takes into account the effects of the researcher and the research strategy on data and findings (Hammersley 1990; Boyle 1994).

Ethnography has gained increased acceptance as a research methodology for the study of health care issues, whether these relate to understanding patients' experiences of illness or care delivery, or understanding issues concerning the organisation and delivery of health care (Savage 2000).

The study represents a focused ethnography in that it deals with a relatively narrow spectrum of the local world of the general practice surgery and that fieldwork began after the main focus of the research had been decided (Kleinman 1992). However, in line with an ethnographic approach, data analysis took place concurrently with data collection, allowing new issues (such as those raised by participants rather then predetermined by researchers) to be pursued.

3.3 Sampling

3.3.1 Organisation

It seemed appropriate in meeting the aims of the study to work in a setting where clinical governance was being successfully implemented. As is shown in Section 1.2.1, the successful implementation of clinical governance is thought to require a process- rather than a function-oriented organisation. Process-oriented organisations have been associated with a number of features and we aimed to select a practice that was characterised by several of these, namely:

- a flat structure, teams-oriented and ostensibly tending towards consensus-based decisions;

- an emphasis on horizontal communication, with

potential for bottom to top communication;

- practice staff moving towards a broad range of competencies.

In addition, we were concerned to find a practice large enough to employ at least three practice nurses.

In reality, we were not in a position to 'select' a practice. In our initial consultation with the chief executive of a local primary care group (PCG) it was suggested that we develop a recruitment procedure that ensured that any practice volunteering to join the study would do so on the basis of collective agreement amongst its staff. There was concern that we should ensure that there was no coercion of individual members of staff to agree where other, perhaps more senior or powerful, members of the practice wished the practice to be involved. This concern was also expressed by members of the local research ethics committee (LREC). Recruitment was therefore eventually based on inviting all practices within a PCG to consider involvement by advertising through the monthly PCG newsletter.

The process of recruiting a practice was also complicated by the fact that, at the time the study began, many potential practices were undergoing a period of considerable change and stress. Not surprisingly, many practices, particularly those that were uncertain if they were really implementing clinical governance, did not wish to put themselves under scrutiny. We therefore found that there was very little response to our efforts to recruit. The senior partner of one practice with a strong clinical governance profile showed interest but, after discussion with members of staff, informed us that research was not appropriate or convenient at this particular time. However, he invited the researcher to a two-day clinical governance conference for PCG members and this provided an excellent opportunity to meet directly with staff from other practices and to introduce them to the idea of our research. Letters of invitation and information were handed out to interested practices.

Our research practice ('Market Street Practice') responded by inviting the researcher to their clinical meeting in order to discuss the study further. They agreed to participate after discussion between practice partners, nursing staff and administrative staff and following a visit by the research project leader.

Figure 3 – Gold's participant observation continuum

⬅ observer … observer as participant … participant as observer … participant ➡

3.3.2 Participants

The study aimed to focus on one multidisciplinary team that included nurses and doctors working in the same clinical setting. The criteria for inclusion of participants from this team were that they should be:

✦ involved in clinical work;

✦ involved in multidisciplinary decision-making;

✦ willing to join the study.

In addition, a small number of additional staff (such as senior managers, representatives of the trust, ancillary staff at the practice) were involved. These were:

✦ members of staff who were present during participant observation within the practice;

✦ individuals who could provide contextual information (for example, trust policy, alternative perspectives on practice issues).

3.4 Methods

The study was designed to include:

✦ participant observation of multidisciplinary forums in which clinical decisions were made;

✦ participant observation of practice;

✦ interviews with staff, including the use of vignettes, to explore their experience and understandings of accountability;

✦ document analysis;

✦ use of a reflective diary by the researcher.

3.4.1 Participant observation

Participant observation is a central plank of research using fieldwork and:

> involves the researcher in prolonged immersion in the life of a group, community or organisation in order to discern people's habits and thoughts

as well as to decipher the social structure that binds them together.

(Punch 1994: 84)

It is employed where researchers aim to identify and explore the ideas that research participants draw on in order to make sense of their lives (Merrell and Williams 1994). Significantly, observation has been described as perhaps the most important way of collecting information within practice-based professions like nursing (Parahoo 1997).

Most accounts of participant observation describe it in terms of points on a spectrum, marking a range of roles for the researcher that traditionally gave emphasis to the collection of visual data. Gold (1958), for example, talks about a continuum from complete observer to complete participant (see Figure 3).

However, as Atkinson and Hammersley (1994) have suggested, these different roles are not clearly distinguished but overlap, depending on:

✦ whether the researcher is known to be undertaking research by anyone in the research field;

✦ how much, and what, is known about the research among participants;

✦ what sort of activities the researcher becomes involved in during fieldwork (and how this influences others' perceptions of him or her in terms of group membership, power, and so on);

✦ the orientation of the research – for instance, whether the researcher aims to become an insider or remain an outsider.

In this project, primarily for ethical reasons, the researcher was known to be undertaking research by everyone in the research field. The strategies for ensuring this are described in Section 3.6, where the ethical issues raised by participant observation and informed consent are discussed. The effects of ensuring awareness of the research and obtaining informed consent are further described in Moore and Savage (2002).

As a 'privileged observer' the researcher adopted a 'participant-observer' role, attempting to share in the

daily life of the practice by helping with general and simple tasks (opening post, filing notes) whilst observing and talking informally to practice staff during their working day.

The researcher observed the work of receptionists at the front desk, informal interactions with staff around the practice, practice nurse clinic appointments during specialist as well as generalist clinics, two general practitioner patient clinics and partners', business and clinical meetings, as well as educational and multidisciplinary practice staff sessions. Fieldwork also included attending clinical governance meetings at a location outside the practice that was attended by members of staff from other practices in the primary care group.

Notes were mostly written up on a daily basis after the fieldwork and away from the practice, except at meetings, where, with the agreement of the staff, notes were made during the meeting. Very occasionally the researcher made discreet notes in a small note pad, away from practice staff and only if she feared she would forget the details of a particular event or statement.

The majority of the practice staff were accepting and friendly, appearing comfortable with the researcher's presence and soon seemed to get 'used to being observed'. In fact, due to the friendly nature of the practice, the researcher developed a reasonably close relationship with the practice staff and felt a certain sense of belonging. She was told that she 'fitted in' by one member of staff, for example, partly it seemed because she lived in a neighbouring town, and was sent flowers from the practice on the birth of her baby at the end of fieldwork. This relationship with the practice staff prompted the researcher to write of concerns of 'going native' in her reflective diary.

3.4.2 Interviews

Informal and semi-structured, tape-recorded interviews were conducted with all willing, available clinical staff on their perceptions of accountability. In line with an ethnographic approach, the focus of discussion evolved to some extent as the study progressed. Due to the sensitive nature of the research, questions during tape-recorded interviews that explored where accountability was perceived to lie in specific situations were distanced from informants' practice by the use of vignettes, as

recommended by Finch (1987) (see Section 3.4.3 below).

Interviews were carried out at mutually agreed times over the last two months of fieldwork. In total 13 interviews were conducted with three general practitioners, four practice nurses, two community staff and four administrative staff.

3.4.3 Vignettes

Vignettes are short stories about hypothetical situations and characters that are presented to research informants as a basis for discussion and provide enough detail of events and context to enable informants to make normative statements about what they describe. Vignettes can either be non-directive, in that informants are given the vignette and allowed to define the meaning of the situation and their response for themselves, or they can be followed by fixed-choice responses, or open questions (Finch 1987).

In this study, two vignettes were used during tape-recorded interviews. Each described an event that might take place in general practice/practice nursing and that raised issues about the location of accountability. Both vignettes were based on events known to have happened elsewhere, although the details were altered.

The first vignette describes the collapse of a patient after a routine visit to a heart disease clinic at which he complains of intermittent symptoms akin to indigestion. The clinic nurse seeks advice from a doctor who is acting as a locum (the doctor who generally works in the clinic and has a special interest in cardiology is away). The locum suggests taking an ECG that he will look at later. The patient leaves, and collapses, before the ECG is read (See Vignette 1, Appendix 2).

The second vignette describes how a patient attends for her treatment for schizophrenia. The patient is known to be suffering from depression, but the nurse has no training in mental health and feels unable to make a full assessment. She does feel instinctively that all is not well and discusses her feelings with one of the GPs at the end of the session. The GP does not believe the patient to be at risk. However, they hear later that week that the patient has attempted suicide (see Vignette 2, Appendix 2).

Participants were asked to read the vignettes and to talk

about where they thought accountability lay in each scenario.

3.4.4 Analysis of documents

Documents studied included:

- the practice booklet;

- minutes of Monday practice meetings;

- minutes of multidisciplinary meetings (skill mix group, cervical smear group, locality planning group, communications group, asthma working group);

- practice development plans;

- protocols for the management of coronary heart disease, asthma, stroke, cardiac exercise group, heart health clinic, ear syringing, leg ulcers, hypertension, and ambulatory blood pressure, travel vaccine;

- the practice profile.

3.4.5 Reflexive journal

During fieldwork, the fieldworker (L.M.) made notes daily after each period of participant observation within the practice. Interspersed between the more objective notes recording the life of the practice, she recorded personal opinion and reflections upon her experiences within the field. For example, as mentioned above, during fieldwork the researcher felt a sense of belonging and began to question whether this could lead to the possibility of 'going native'. She recorded comments about the relatively close relationship that was developing between the herself and the staff and how her growing respect for them might affect her observation of their everyday work. Through keeping reflexive and personal comments throughout the fieldwork, she attempted to maintain a level of accuracy and a sense of perspective about her presence within the field.

3.5 Data analysis

Data from interviews were subjected to thematic analysis and then compared with data from participant observation.

Themes were identified using a manual method without the use of a computer program, looking for commonalties, meanings and patterns within the transcripts of informants' statements and within fieldnotes. These commonalities were then coded, paragraph by paragraph. Initially several key themes and subthemes were identified and this process was refined through further reading and rereading of the texts. A mental mapping exercise was used in order to attempt to elucidate further meanings and help to make sense of the data.

3.6 Ethical considerations

Approval was sought from the local research ethics committee serving the trust in which the study was located. The principle ethical issues anticipated concerned:

a) *Informed consent and the need to ensure that all participants understood the nature of the study and freely consented, and were aware of being able to refuse or withdraw at any point* (see consent form and participant information sheet in Appendix 3).

- Written information on the study and the implications of participation was distributed, and verbal consent was sought from all practice staff at the outset of the study. Further written consent was sought from all practice staff as they became involved, at least 24 hours before involvement. In the case of participant observation, following guidance from the Association of Social Anthropologists (see Appendix 4), ongoing verbal consent was sought initially on a daily basis from those staff on duty who might enter into the field of data collection. Later, at the request of staff, ongoing consent was assumed unless staff indicated otherwise. Only two members of staff declined to be observed during consultations with patients, but they agreed to be observed at meetings and at other times during their working day.

- Interviews with health care staff were arranged at least 24 hours in advance, at which point potential participants were given information sheets about the study and had the opportunity to ask further questions. Written consent was then sought immediately before the interview.

✦ Patients attending the practice were not interviewed but some were asked for permission to observe their consultation with practice staff. Patients were given information sheets about the study when they arrived at reception, and were asked for informed consent while they were waiting to be seen.

b) *Confidentiality: importance of protecting the identity of participants and the organisation.*

✦ Data from tape-recorded interviews were transcribed by a designated person, qualified in transcription and who had signed a confidentiality statement.

✦ Anonymity of the research participants was maintained by substituting anonymous codes for names, with only the researcher and the supervisor having knowledge of the original names of participants.

✦ Data entered onto computer were password protected and all other forms of data were locked securely, with access available only to the researcher and supervisor.

✦ Participants were asked when they gave informed consent for additional consent to use anonymous quotes in written accounts of the research.

c) *The importance of identifying individuals or mechanisms for dealing with problems or distress arising during the collection of data.*

✦ A figure from outside the practice who had no involvement in the research was identified through the local Practice Nurses Forum. This person agreed to act as mediator and source of support for any participant or potential participant who wished to discuss participation in the study or who became distressed by discussion of the issues focused on in the study.

4. The research setting

The general practice in which the research took place was set in a rural location in the south of England, in a largely affluent market town with relatively low unemployment.

4.1 The premises

The practice was set in a three-storey, Georgian listed building on the high street in the town. The building was well-maintained and decorated to a high standard with carpets and paintwork in pastel shades. Considerable attention had been given to creating a pleasant environment for patients and staff. On the ground floor of the building was a spacious reception area that connected to a large waiting room with seating for about 20 people, a children's toy and book area and a good supply of health information and more general magazines. There was access from reception to an extension of the original building where the dispensary, computer systems, notes and filing systems were kept. This extension also contained the coffee and meeting room. This was a large, well lit, pleasant space with seating for about 12 people, newly carpeted and decorated, and equipped with a computer terminal and book shelves. Next door was small kitchen, generously stocked with coffee, tea and biscuits. Staff were encouraged to make use of this space during lunch and coffee breaks but interestingly, it was often referred to by staff as 'their room', meaning the partners' space. The space was also used for informal discussion, formal meetings, such as the weekly practice meetings, and educational activities. The ground floor also accommodated the senior partners' room, facilities for patients with reduced mobility and a patients' lavatory with baby changing facilities. On the first floor were a further five consulting rooms and a small waiting area, one spacious nurse treatment room and the health visitor's office. The second floor provided a quiet attic room for counseling, as well as offices for the practice administrator, finance manager, secretarial and data entry staff.

4.2 The practice

The practice served a patient population of approximately 6,500 covering surrounding villages for a radius of six miles. Several (four) nursing homes and a local community hospital were within the catchment area. Practice hours were usually from 8.30 a.m. until 12 noon and from 4 p.m to 6.30 p.m. Monday to Friday, and the practice shared out-of-hours cover with a co-operative of practices providing service for a local area of approximately 20 miles.

In the 1990s the Market Street Practice became a fund holding practice until the election of the present government. Finances from this period allowed for the building of an extension to the premises. It appeared an affluent practice with an above-average income. The partners owned the premises and the adjoining shop, which was rented out to tenants and provided a further source of practice income. The remit of the practice was expanding with initiatives such as the development of a pharmacy.

The practice presented itself as friendly, modern in outlook – for example, it was among the first to be computerised – with a low turnover of staff and an emphasis on teamwork, collaboration and multidisciplinary working. There was an explicit commitment to quality and innovation from some members of the team, perhaps initiated by the senior partner's role as clinical governance lead for the PCT. There was also commitment to investing in the premises, with some discussion at the time of the study about moving to new premises to cope with increased work and patient numbers.

Observation of the practice suggested that work was pressurised, with increasing workload, service provision and meetings in response to clinical governance initiatives and the move towards primary care trust status. Despite this, the practice was characterised by good working relationships, high levels of communication and motivation, loyalty and considerable good humour. The difficulties of day-to-day practice were offset by thoughtful gestures towards practice staff, such as a generous supply of refreshments and high-quality sandwiches for staff at meetings.

Market Street was a popular training practice with registrars, partly because of its high training standards and friendly working environment. The practice had frequent visitors and was used to being observed,

features that no doubt influenced the willingness of staff to host our study.

4.3 The partners

In the 1980s the practice had three partners, now increased to five, with a ratio of two full-time (male) to three part-time (female) general practitioners and a retainer (also female) employed on a part-time basis to provide further clinic sessions and cover leave. The senior partner, Richard Smith, who worked full-time, had been based at this practice for over 20 years. The other partners, Nicholas Reynolds, Emma Scott, Carol Bridges and Claire Long, had worked at the practice for between two and 17 years. (All names used in the report are pseudonyms).

The senior partner took responsibility for the practice finances and had a clinical governance link with the primary care trust (PCT). The responsibilities and interests of other partners included the education and training of practice staff and visiting medical registrars, as well as clinical governance support at a practice and PCT level. Specialisms of practice members included mental health, young people's health, women's health and the treatment of ear, nose and throat conditions.

4.4 The practice nurses

The partners employed four practice nurses, all on a part-time basis, who worked between one and four days per week. Two of the nurses, Alex Rose and Vicky Gardener, had been based at the practice for over 15 years, while the other two (Laura Walby and Sarah Watson) had taken up posts during the previous two years. Most nurses lived locally and the two longer-serving nurses had known patients ('regulars') for many years and were on a first-name basis with several of them.

According to the practice development plan, the nursing strategy prioritised the management of chronic disease, and nurses had run their own disease prevention and management clinics since 1985. All nurses offered general nursing care, blood tests, dressings, family planning and cervical smears, well person checks and health promotion in clinics throughout the week. In addition, the senior practice nurse specialised in clinics related to the management of coronary heart disease,

hypertension and exercise. A second practice nurse offered clinics for diabetes care and asthma management, while a third specialised in travel health and vaccinations, including child immunisations in conjunction with the health visitor. Practice nurses were also on a rota to contribute to the running of a nurse-led leg ulcer clinic at the local community hospital once a week. A practice nurse also co-ordinated a patient exercise class once a week and a health promotion and young persons' clinic at a local school.

Nurse-led clinics took place in either the morning or afternoon of each day and lasted for approximately four hours. Each patient was designated, on average, a 10-minute consultation time, although some longer appointments of up to 30 minutes were available, depending on clinical, technical and educational needs. Ten-minute coffee breaks were scheduled for nurses during a morning clinic, although these breaks were difficult to take due to pressure of work. Nurses worked according to protocols that were written and agreed by practice nurses and doctors working in the relevant specialism. The practice had largely computerised patient records, but old notes were still available and used by some staff alongside computer records. Generally speaking, nurses documented care for each patient on computer, using templates for certain diseases that also offered some opportunity to record free text.

The practice nurses had varying levels of service and training, with backgrounds in acute or community care. Initially, most of their training and education was organised on an 'in-house' basis, by either a fellow practice nurse or a general practitioner. Subsequently, training became more diverse – a mixture of in-house, multi-professional (with nurses and doctors training each other in mixed and single specialist groups), self-directed, trust organised or drug-company-sponsored. Partners, particularly the partner designated practice educator, were committed to continuing professional development and nursing staff had relatively good access to training. However, there was some disparity between the training opportunities available to community nurses (that is, district nurses and health visitors), for whom there were agreed standards of training and attendance at education sessions, and practice nurses. For practice nurses, training opportunities were offset by the problems of finding cover or finding the money for training.

4.5 Community nursing staff

There were two members of community staff, a full-time district nurse (Angela Jones) and a part-time health visitor (Alice Kelly) who were 'attached' to the practice but employed by the PCT. Both liaised with and accepted referrals from partners at the practice as well as working in collaboration with colleagues from other practices in the area. The community nurses were also invited to attend a lunchtime clinical meeting at the Market Street Practice once a month to discuss patients with specific GPs.

The district nurse cared for patients in their homes as well as co-ordinating the leg ulcer clinic at the local hospital and assisting with a nursing service for the terminally ill, available to local residents and run in conjunction with practice partners, the Macmillan team and local charities. The health visitor was based in the practice and shared a room with another health visitor who had a different 'patch'. The health visitor's responsibilities involved the care of children from birth to 5 years, including vaccinations, health checks, developmental issues and the surveillance of children at risk. Further work included pre- and postnatal support, the care of families with special needs, women's and men's health and health promotion. Both the district nurse and health visitor were under increased work pressure due to staff shortages.

4.6 Administration, reception and other staff

In addition to a practice administrator and a business manager there were a number of clerical, audit and secretarial support staff based in attic offices on the third floor of the practice building. The practice administrator (Cheryl Henderson) had been employed with the practice for almost 20 years, since her work experience placement. She was responsible for co-ordinating the daily running of the practice, organising partners' meetings and on-call rotas. She was also responsible for six receptionists (either full or part time), and a further two staff who were employed in the pharmacy. Towards the end of fieldwork, two further pharmacy staff began work on a part-time basis.

The business manager (Gwen Forrester) had been employed for two years, having previously worked for a housing association in a similar role. She was

responsible for the day-to-day finances of the practice, namely payment of salaries, wages, bills and ensuring the practice received payment for 'items of service' from the health authority. She also co-ordinated the call handling service for the area and attended clinical governance meetings at the PCT. As part of the management team for the practice, she played a role in cascading PCT information down to other members of staff.

The receptionists were overseen by Christine Rye, the senior receptionist or 'team leader'. Reception staff were responsible for the 'front of house' practice area, and duties included booking patients' appointments, answering patients' queries, giving out prescriptions, answering the telephones and organising the notes for the clinics. A key role was to record all messages received from patients, the public and hospital and community staff related to patients, visits and urgent requests or queries. Reception or 'downstairs' was described by the practice administrator as the 'engine room' of the practice. Many of the staff working in this area had years of experience and had considerable knowledge of patients and their needs. Two part-time counselors were also based at the practice.

4.7 Meetings

Meetings of the practice team played an important role in the running of the practice. According to several staff, these meetings had increased considerably over several years. Clinical staff attended:

✦ A practice meeting held every Monday between 12.45 and 2 p.m. Each month there would be:

  ✦ two clinical meetings involving the senior practice nurse, district nurse, health visitor, GPs, administrator, Macmillan nurse and counsellors;

  ✦ one business meeting involving the business manager, GPs and administrator; and

  ✦ one partners' meeting attended by the GPs and administrator.

✦ A monthly education meeting for all available staff.

✦ A monthly critical incidence meeting for partners and nurses.

✦ Meetings for staff with specialist interests, for example heart disease, diabetes, asthma, hypertension and cervical smears.

✦ Meetings for those designated to consider skill-mix, locality planning and communication issues at the practice.

✦ Multi-professional group meetings, arranged at regular intervals throughout the year and attended by partners, nurses, receptionists and secretarial staff at the practice.

Each of these meetings was chaired by one of the practice partners who fed ideas and proposals back to other partners at the Monday meetings. Until about 18 months before the fieldwork period, the Monday practice meetings used to include administration, clinical and everyday items mixed together. It was then established at an awayday that these meetings were 'dreaded' and inefficient, and instead, every Monday now has a specific remit, with a partners' meeting, a business meeting and two clinical meetings every month. There were issues about partners 'hijacking' these meetings and therefore it was agreed that the business manager or the administrator should chair the business and partners' meetings. One partner, on a weekly rota system, usually chaired the clinical meetings. One clinical meeting a month also extended an invitation to the counselors and the Macmillan nurse for the area. The senior practice nurse usually attended and represented the practice nurses.

The practice also had a management team comprising partners, the senior practice nurse and the administrator, who, because of their attendance, were consequently more involved in the decision-making process at the Monday meetings. However, all staff were invited to contribute to the meeting agenda and attended to discuss their ideas. In addition, some staff also attended clinical governance meetings run by the PCT that took place outside the practice.

5. Findings

This chapter gives details of the findings of the study, drawing on data from interviews, the use of vignettes and participant observation. Findings relate to three broad areas: the ways in which accountability was understood in theory, the way accountability related to practice, and issues and concerns raised by accountability. Although the study involved members of staff from across the practice, in line with the aims of the study, we have tended to focus predominantly on the issues that accountability posed for practice nurses.

5.1 Understandings of the concept of accountability

Given the abstract nature of accountability, attempts were made to gain access to this concept using a multi-method approach. Participants were asked directly about the nature of accountability. They were also given vignettes to consider which explored the location of accountability in specific circumstances, with the aim of teasing out the norms underlying practice. Finally, the day-to-day work of the practice was observed, with a view to understanding what accountability meant and where it was located. This section first explores the data from direct questions about the concept of accountability put to informants during interviews.

No single, unified way of understanding accountability emerged from the direct questioning of staff about this concept. Some practitioners were unclear about the meaning of the term; as one GP said, 'I mean I am not terribly sure what I mean by this word accountability'. Interestingly, another GP made the comment: 'I have a vague feeling, it is only a vague feeling of accountability. I cannot give you a definition because it is a relatively new term if you like.'

Significantly, none of the nursing staff suggested that accountability was a new issue, reflecting perhaps the different preoccupations of medicine and nursing (as discussed in Section 2.5.2) and the significance of accountability in the professionalisation of nursing. There appeared to be some inconsistency in how accountability was understood within the practice, as was suggested by the health visitor: 'I suppose what I am trying to say is different people interpret accountability differently'.

At the same time, accountability was seen to be different in nature, depending on the groups or bodies to whom practitioners were accountable. One of the partners, for instance, was clear about his accountability to patients but unsure about his accountability to the government, saying:

> … they do not define very clearly what my accountability … where the boundary of my accountability is and therefore obviously I unless it is clearly defined it is very difficult for me to feel that accountable really.

GPs tended to see themselves as assuming risk across all areas of the practice. While their accountability was seen as unbounded, it was thought – at least by some – that accountability was becoming more circumscribed for other members of the health care team. Nurses, for example, were increasingly working to protocols which defined appropriate actions and helped establish the boundaries of their accountability.

However, despite these differences, a number of common threads can be identified concerning the way participants answered the question 'What does accountability mean to you?' These common threads included:

✦ the conflation of accountability and responsibility;

✦ understandings of accountability/responsibility as:

    ✦ an imperative,

    ✦ a relationship;

✦ the ubiquitous nature of accountability (and uncertainty) leading to defensive practice.

5.1.1 The conflation of accountability and responsibility

Only two participants made a distinction between accountability and responsibility. One GP, Nicolas Reynolds, talked about accountability in terms of 'ultimate responsibility', with accountability at the top of a pyramid of hierarchically organised responsibilities:

> I think accountability is defined as which person or health care professional takes ultimate responsibility for a clinical situation that comes up, or takes responsibility for the health or the needs in the broadest sense of the patients under their care, and – if you are going to take ultimate responsibility – what qualifies you to do that.

He went on to suggest that the degree of responsibility that an individual practitioner might accept would depend on their status and background.

Alice Kelly, a health visitor, made a similar type of distinction between accountability and responsibility. Although she did not explicitly state that accountability was the highest level of responsibility, she implied this by saying that it was possible to apportion responsibility to others through the delegation of tasks, while retaining accountability: 'You can give somebody responsibility to do something but you are still accountable for what they do'.

In contrast, for most of those in the study who were asked to explain the concept of accountability, it was conflated with responsibility. For example, one nurse said: 'I think accountability is [about] responsibility. It's about feeling and knowing that you are responsible to individuals, to yourself and your employers.'

This lack of distinction between accountability and responsibility permeates the data. In numerous conversations about accountability, participants might begin by talking about their accountability, but would shift towards use of the term responsibility. Moreover, this 'slide' was so subtle that it often went unnoticed at the time by the researcher. This poses a problem in the interpretation of the study's findings, as it has to be assumed that, in many contexts, when participants referred to 'responsibility', they might be alluding to accountability.

We deal with this conflation in the following ways:

a) we interpret the meaning of the term 'responsibility' (and whether it is used to stand for 'accountability') on the basis of the context in which the term is used;

b) we infer from the way that accountability and responsibility are conflated that, for many participants, and in many contexts, accountability and responsibility are seen as virtually synonymous.

5.1.2 Different understandings of accountability/responsibility

Participants found it very difficult to articulate their understanding of accountability but two alternative interpretations were suggested by the data.

5.1.2.1 Accountability as imperative

Some informants implied that accountability was an attribute or property held by an individual that in some way impelled them to make a decision/take an action (or refrain from action). For example, accountability was described as 'a point where you think you really have just got to do something, you've got to take some kind of action yourself'.

Alternatively, accountability was described by some as accepting the consequences of actions. For example, one practice nurse stated that 'Accountability to me means responsibility for my actions'. Or, it might be explained in terms of being able to give an account, to provide reasons for one's actions. For example, Alice Kelly, the health visitor, stated that:

> Accountability is your answerability: you have to be able to justify what you do and you have to be able to justify that you have acted in the best interests and that, yes it is who you are answerable to.

In some participants' definitions, a more process-oriented depiction emerged in which accountability was both a catalyst and a continuing feature of action: 'It's a decision that you have to take some kind of action and be responsible for seeing that through'.

There was some suggestion that only certain kinds of decisions should inform this process, namely those that were rooted in 'evidence': 'It's about understanding the evidence and how to use it to promote good clinical practice and take responsibility for one's actions, within reason' (Sarah Watson, trainee practice nurse).

Accountability might be inherent in a decision not to take action, provided that the decision *not* to act was evidence-based (according to Sarah), or informed by an understanding that action in a particular context lay beyond the boundaries of a practitioner's knowledge or role. Angela Jones, a district nurse explained this as follows:

> Well really, I'm accountable for what I do and if there's something that I didn't think I should do

then I won't do it. If it's something that I think it's not my reame, I won't do it.

For some, the concept was explained with regard to where professional onus could be placed, the point at which *responsibility* could not be passed on any further to others:

> It means responsibility to me … where the end of the line …who actually makes the decision and makes themselves responsible for a decision one way or another, for actually making the decision and not just trying to pass it on or make an excuse, or find an easy way out of it.
>
> (Sarah Watson, trainee practice nurse)

In defining accountability, one of the GPs, Emma Scott, brought together many of the elements referred to individually by other respondents, namely the way accountability and responsibility are closely associated, the link between actions, decisions and best available evidence and, in addition, brought in the spectre of the law courts:

> I would say [accountability] is accepting responsibility for what you are doing … and knowing that whatever you have done, you can account for it. Whatever decision you make you're hopefully making it in the best interests of your patients and based on the best evidence there is at the time, and being able … be prepared to stand up in court if it came to it to say 'yes, I did that – these are the reasons that I did it for'.

5.1.2.2 Accountability as relationship

Rather differently, instead of being an impulse to act, accountability was also discussed in terms of the relationship it described. As one GP put it, accountability was being 'accountable to somebody for something'. However, those to whom practitioners considered themselves accountable to appeared to vary. For instance, one of the GPs, who provided the most comprehensive definition of accountability, defined it largely through identifying those to whom he felt accountable:

> … in terms of my medical work I am accountable to, primarily, the patients for my clinical work, but also to the much broader team, in a variety of ways – both in terms of making sure I pull my weight for my own work, and making sure I help others in theirs, making sure I help people develop with clinical skills. And the patients, I hope, if they thought about it, would expect me to

be accountable to them for making sure I remain skilled. I am also accountable for those things to the people who pay me and give me a contract, which are the Health Authority and, ultimately, the Secretary of State. And there is a broader accountability to colleagues and so on.

Significantly, when nursing staff defined accountability, they generally did not say to whom they considered themselves accountable. Instead, much of what they said *implied* their accountability was to the patient. Moreover, one nurse suggested that an integral part of accountability was knowing 'who to turn to for support when you need it'

5.1. 3 The ubiquitous nature of accountability

Some of the nursing staff implied that practitioners' accountability had increased, and felt that they now had an increased awareness of their own accountability and the need to document their actions in order to protect themselves from litigation. The district nurse, for example, stated that practitioners were accountable for their every action, and needed to document everything that they did 'because you never know, do you?' When asked to elaborate on this statement she added:

> … because people are out to get you now, aren't they? They will sue you as quick as lightening, won't they? So you've got to be, haven't you, you've got to be covering yourself at all times.

Nicolas Reynolds, one of the practice partners, emphasised that accountability was becoming more and more of an issue and that this had implications for resources:

> I mean, if we are being asked to be accountable for more and more things, obviously the amount of attention to detail that we can put into each of those individually is less and less … which is a very frightening thing …. In the last ten years, more and more things have come out and they have been pushed towards us saying 'Yes you are accountable for that', 'yes you can to that', 'you can do that', 'you can do that' but we are not given the support, financial resources, staff … everything to actually take on that accountability.

As a result, he suggested, it was becoming increasingly important to clearly define what clinicians were, and were not, accountable for.

The ubiquitous nature of accountability, the sense that practitioners were being asked to accept increasing levels of accountability, and the uncertainty about the limits of their accountability was seen by some participants to influence the nature of their practice.

5.2 Accountability in practice

This section draws on data from interviews and vignettes, with some support from participant observation. It begins with an exploration of how participants understood accountability and its location in specific circumstances. Two vignettes, one describing the care of a patient who later had a myocardial infarction and the other outlining the care that preceded an attempt at suicide (see Appendix 2), were described for a number of staff (practice nurses, GPs, a health visitor and district nurse), who were then asked to comment on the issues raised. The vignettes were helpful in that they dealt with hypothetical issues of practice and thus allowed research participants to discuss the location of accountability without fear of criticising or incriminating themselves or their colleagues.

5.2.1. Data from vignettes

The responses to each vignette are summarised below, and the main points to emerge from the vignette exercise are then presented.

5.2.1.1 Responses to Vignette 1: myocardial infarction

The responses made by each participant to the vignette are summarised in Figure 4.

Figure 4 – Responses to Vignette 1

Health visitor	Both the nurse and original GP are accountable (even though this GP is absent) as they set up the clinic. The GP who stood in for the absent GP is responsible. A distinction is made between nursing and medical accountability. The nurse should cover herself by insisting a GP reads an ECG or by writing up that she has asked for this to be done.
District nurse	The GP is probably accountable, but the nurse should have insisted that he read the ECG, so she is accountable in some way.
GP	The doctor should retain responsibility. An ECG should only be carried out if there is someone to read it. If a doctor orders an ECG they should see this through, and read it. This respondent describes a similar episode that he knows of that has informed practice policy. He suggests that the nurse in this case is not accountable: where nurses are working in a medical area, the medical side retains accountability (although nurses will be supported by protocols). The nurse would be accountable in a situation of nursing expertise, for example leg ulcers.
GP	The GP is accountable without question. The GP is responsible. The nurse should not do training to read ECGs unless she is going to be doing this all the time. Final accountability is the doctor's but cannot carry out accountability function without the help of colleagues: 'You are grateful when they pick things up'. Hint that the nurse should have been more assertive.
Practice nurse	This is an example of shared accountability. The nurse did not do anything wrong but will feel bad that she let the patient go. The nurse was aware that the specialist GP was absent so her accountability increased. Because she had set up the clinic with the specialist GP, and it was nurse-led, these two should take responsibility. The stand-in doctor does not have accountability. He did nothing wrong.
Practice nurse	Taking an ECG raises big accountability issues. An ECG should not be taken if it is not going to be read. The GP is responsible – there should have been clear guidelines in place to prevent an ECG being taken without ensuring it was then read. The nurse also should recognise responsibility for decisions she made.
Practice nurse	The GP is accountable. The nurse largely did what she was supposed to do.
Practice nurse	This was a nurse-led service. Should have had protocols. It seems like the nurse and GP who set up the clinic have not relayed sufficient information to colleagues. The attending GP ought to have read the ECG. The nurse did what she could within her limitations. Both are accountable but the GP is more accountable than nurse. ['If it were me, I'd feel responsible that I hadn't done more.']

A number of points emerge from this vignette. First, accountability is used interchangeably with responsibility. Second, there is a wide range of opinions on the location of accountability. Some see that the original GP is accountable (and to a lesser extent the nurse) because the clinic was set up without clear protocols to inform staff on practice while working in this clinic. Others see the locum doctor as accountable. Third, accountability is not stable. Individual accountability, for example, can change in the absence of a particular colleague. Fourth, accountability can be apportioned. A couple of respondents see that accountability is shared between staff while others suggest that there are degrees of accountability – all parties may be accountable but some are more accountable than others. Fifth, accountability is role-specific. There is the suggestion that nurses and doctors have different kinds of accountability. Sixth, there is some conflation of accountability and blame, if not emotion: one practice nurse, for example, states that in this scenario there is shared accountability – the nurse did nothing wrong (and is therefore, this suggests, not accountable) but will feel bad about her actions.

5.2.1.2 Responses to Vignette 2: attempted suicide

The responses made by each participant to the second vignette are summarised in Figure 5.

The main points here are first, that again, there is considerable variation in the way that accountability is understood. There is a stronger sense in this example, however, that each practitioner is accountable for his or her own actions. Second, accountability is not unstable in the way suggested above (Vignette 1), but may be dependent on experience: the nurse, for example, would have been more accountable if she had a training in mental health, and the doctor more accountable if he had seen the patient more recently. Third, for some respondents, accountability is apportioned not in response to clinical judgement but on broader actions, such as the failure to secure, or to facilitate, appropriate training, or the failure to make one's voice heard. Fourth, there is also a suggestion that accountability has a relationship to specialism – accountability, for example, becomes more difficult in the specialism of mental health.

Figure 5 – Responses to Vignette 2

Health visitor	Each practitioner is accountable for his or her own actions in this situation. The nurse might be accountable for not making a sufficiently clear referral.
District nurse	The GP is accountable. The nurse should not have been dealing with this patient – she did not have sufficient experience. The GP should have made it possible for the nurse to do the mental health course.
GP	Accountability is very difficult in this situation. Unless the nurse has a clearly defined mental health role, she cannot be held accountable for attempted suicide. Accountability is particularly difficult in mental health. If a mental health patient has not been near a doctor for years, the doctor is not accountable for what happens. But if he or she is seeing a patient on a regular basis, the situation is less clear and the GP may be accountable to some degree.
Practice nurse	The nurse is accountable to herself here. She needs to convince the GP that she needs appropriate training. Also needs to work within frameworks. Both the nurse and doctor are seen as accountable in this situation. The nurse is accountable for the care she gives – and for ensuring she obtains relevant training so she can improve her care. The doctor is accountable for blocking the nurse's appropriate training.
Practice nurse	The doctor is accountable – it is the GP's patient and the GP knows her best.
Practice nurse	The nurse did not feel in a position to question the doctor's view. Both are accountable. Nurses have to have the strength to speak up.

5.2.1.3 Points to emerge from the vignette exercises

Among the clearest points to emerge from the vignette exercise are the conflation of accountability and responsibility, the range of understandings about accountability and where it could be located, and the lack of any pattern about the way different informants thought about accountability. There was, for example, no clear difference in the way that doctors and nurses spoke about it, although it would take a larger study to be more sure about this. Significantly, the more thought participants gave to the meaning of accountability, the more elusive it seemed to become. As one health visitor said, 'The more you use the term "accountability", the more you wonder what it means'.

As Finch (1987) has suggested, vignettes are particularly useful in helping to identify social norms. At one level, the question of who was accountable was interpreted in terms of who was to blame, generally for a failure to act rather than a wrong action. At another level, the vignettes helped identify the importance attached to establishing and/or working within frameworks, passing on information to colleagues and ensuring they have as much information as possible in order to make sound decisions. This was most notably the case where the doctor who set up the heart disease prevention clinic was thought to remain accountable for mistakes that happened in his absence. There was a sense that he was blamed for the incident in Vignette 1 because he had not passed on appropriate information to colleagues. In contrast, the doctor who was present at the time was not seen to be accountable, at least by some respondents. The vignettes also suggested something about the weight given to expertise and knowledge: accountability was reduced in the absence of expertise or knowledge about a patient. On the other hand, practitioners were expected to ensure that they (or their staff) had appropriate training: they were seen as accountable (blameworthy) for poor practice where they had not ensured this.

5.2.2 Data from interviews and fieldwork

The rest of this section on accountability in practice concerns findings from sources other than the vignettes, notably the interviews with participants and participant observation of practice. The themes that emerge from data from these sources concern the ways in which

participants discuss responsibility/accountability, lines of accountability, ways of working, decision-making (including sources of information) and documentation.

5.2.2.1 Responsibility

Given the ways in which participants conflated accountability and responsibility (see Section 5.1.1), it was not always clear during the study what it was that participants meant when they used either of these terms. This section looks at when and how participants used the term 'responsibility' in conversation (and not in response to direct questions about the concept of accountability), with a view to gaining a better understanding of the meanings attributed to the term.

Individual and shared responsibility

Practitioners talked about how they were, at one level, individually responsible for their actions or omissions but that this individual responsibility coexisted with a different kind of responsibility that could be shared. Thus, Vicky Gardener, a practice nurse, described the difference between working on a ward environment where 'responsibility seemed to be dissolved a little' because it was shared across the nursing team, and the individual level of responsibility that accompanied practice nursing, which was characterised by 'working alone' (see Section 6.1). Referring to her decision-making in the primary care context she stated that 'I would feel that I'm responsible for the decision myself always'.

Similarly, the senior practice nurse described a personal sense of responsibility: ' I think that as every patient comes into the room you immediately feel your responsibility to see that this patient's needs are met as far as you're able'. Although she implied that she would seek advice if unable to fulfil this responsibility, the burden of responsibility seemed to weigh quite heavily on her. She described nursing practice as a 'huge responsibility'.

This same nurse also suggested that, in addition to an overarching kind of responsibility for their own practice, nurses had particular areas of responsibility within the practice team. She proposed that: 'the idea really is that all the nurses can do most things but they all have their own areas of responsibility to make their own'.

Doctors also worked in this way, with both general and specific responsibilities. Richard Smith, for example, took the lead on the treatment of asthma and thus

accepted a form of responsibility for overseeing asthma care (ensuring evidence-based practice, for example). At the same time though, he believed that each doctor who treated a patient with asthma was responsible for his or her own care at an individual level. Taking a leadership position in a particular area did not necessarily mean that he carried responsibility each time a patient was treated within the practice. As he put it: '… how we look after asthma in this practice is a responsibility which the practice as a whole signs up to and each professional doctor is responsible'.

Passing on responsibility

Several interviewees described a reluctance to take responsibility, or the sense that ultimate responsibility did not lie with them. One of the practice nurses, for example, said of the general practitioners at the practice: 'They're the ones that are really, well, in charge really. I'm not a great one to want to take all responsibility.' In line with this, the business manager, Gwen Forrester, commented that, although all staff took responsibility for errors, she believed that medical staff were ultimately responsible: 'I think we all take responsibility for mistakes that we make and I think we'd be wrong not to but, as I say, the onus definitely is on the doctors at the end of it'.

Patients too were seen to need to take responsibility for their own actions. For example, one practice nurse suggested that, although practice nurses needed to inform patients about the need to take precautions when going abroad, such as getting vaccinated or understanding potential sources of infection, patients also had to 'take a little responsibility for themselves'.

5.2.2.2 Lines of accountability

Different lines of accountability were described by participants, with accountability to the practice partners a key theme. Non-clinicians tended to see themselves as having uni-directional accountability or responsibility to partners or their line manager, while clinical staff might refer to multiple lines of accountability. Whether or not those interviewed talked of their accountability to patients also appeared to depend on role.

Accountability to partners/doctors

Members of the administrative and ancillary staff emphasised their accountability solely to the partners/doctors, or to one particular partner where they had a direct working relationship. When asked who she saw herself responsible to, one receptionist interpreted this in terms of loyalty, stating:

> Well, ultimately to the partners but I feel most loyal I think in my role in pharmacy to Nicolas (GP) because he puts a lot of time and effort into making it a success.

Rather differently, the business manager described her accountability in terms of answerability and preventing mistakes:

> Well basically … I'm accountable to the doctors. At the end of the day if I miss something, they lose out financially so from my point of view I have to make sure that I'm thorough and that I approach everything fairly methodically.

In a further variation, Cheryl Henderson, the practice administrator, suggested that her accountability was primarily to the senior partner and then, depending on the situation, to other partners:

> I'm basically accountable at the end of the day to Richard, who is the senior partner. He is the person I keep in close contact with … really my links to people are Richard as a senior partner or any other partner depending on what the problem is if it's within their remit.

She contrasts her relationship to the partners (a relationship which is characterised in part by her accountability to them) with her relationship to other staff (where she talks more in terms of liasing, or sharing information).

The senior receptionist also described two levels of staff to whom she was accountable: 'I'm accountable to the doctors and Cheryl, because she's my boss'. This is still unidirectional accountability as these different members of staff were in the same hierarchical line of management.

Multidirectional accountability

Other members of staff, namely clinicians, described their accountability as more multi-directional, mentioning their accountability to partners or doctors as well as making reference to one or more other lines of accountability. For example, the senior practice nurse stated:

> I think I'm accountable to the partners in the practice … but I feel it's mainly an accountability to myself because I work on my own so much, a nursing accountability really.

Although she mentioned the partners first, this personal/nursing level of accountability appeared more dominant, prompted for this practice nurse by the nature of her work but also perhaps by the lack of nursing line manager.

Angela Jones, who as a district nurse was not employed directly by the practice partners but was located within a nursing management structure, suggested that she was accountable to ' myself, people I work with, the patient, the GPs, my manager and health authority, basically'. These multiple lines of accountability include the patient and doctors, but the primary line of accountability was not clear.

Richard Smith, (senior partner) also talked about multiple lines of accountability, which proved quite complex. He suggested that accountability could be understood not only as an ongoing commitment or relationship, as with partners or patients, but also as situational, depending on what was happening and who was involved:

> I think it varies to whom we are accountable, so in respect of the rent of the shop next door [which he was responsible for collecting], I am really accountable to my partners, and that is all. If you are taking training decisions – we, as a practice … but C [GP] is the nominated trainer so she would be accountable to the registrar.

Furthermore, with respect to clinical decisions, 'the person who is accountable varies, depending on who's got certain interests', referring here to specific areas of practice for which a practitioner may take the lead. Thus, whoever leads the cervical smear group, for example, would seem to be accountable for suggesting and implementing changes to the procedure for cervical smears within the practice.

Accountability to patients

One particular GP emphasised his accountability to the patient first and foremost:

> … basically I would see myself accountable to the patient directly, what I do, I hope they would feel I was accountable for … but I hope the check is on with the patients in that if I feel I have done my best and I feel I have been fair to the patient then at least that's the easiest way of looking at accountability.

Other interviewees stressed their accountability to the patient, after mentioning other lines of accountability.

For example, the trainee practice nurse considered that, if she were employed as a practice nurse, she would be accountable to:

> … the primary care trust … I think that's who I'd be accountable to and to the patient, very much so … Mostly the patient, I feel that whatever happens to me, if I'm not giving somebody the care that they deserve then I am very much accountable to them.

Here accountability appears to be concerned with omission – that it exists, or comes into play, when something is not done, rather than being a constant feature of practice.

Equally, Alice Kelly, the health visitor, saw herself accountable to the profession and employers but emphasised her accountability to clients:

> Yes, I think on a … day-to-day I feel … I am quite conscious that we have to be accountable to clients, you have to give them the service, you have to give them the reasons …

5.2.2.3 Ways of working

Ways of working emerged from the data as an important issue. There were four distinct subthemes: working alone, teamwork, working with 'differences' in practice and working in the same way, all of which raised important issues about accountability.

Working alone

Data from interviews suggested a close relationship between accountability and ways of working: certain ways of working posed specific issues for accountability. In particular, 'working alone' appeared to be an important theme for the majority of practice nurses, who made very similar comments about the independent nature of their practice and what this suggested about their accountability. In contrast, a fourth practice nurse did not talk about working alone, but emphasised that she would 'always' consult with a doctor. In contrast to the experience of other practice nurses (see below), she stated that she did not feel pressured either to take full responsibility or to work without consulting the doctors, saying:

> If I'm ever worried about anything, I always go and refer to the GP…they're the ones that are really, well, in charge really. We take a certain amount of it. I'm not a great one to want to take all responsibility.

This nurse's style of practice was different to that of other practice nurses in that she appeared less convinced than others about the value of some of the changes taking place in primary care, and was to some extent selective about which of these she took on board. Other members of staff appeared to accept this different approach and recognise its benefits. For example, the detailed attention that she gave to decision-making regarding individual patient care was highly valued, especially as this often raised more general questions about the clarity of practice protocols.

For the other practice nurses, 'working alone' had two dimensions to it. The dimension most commonly referred to concerned the isolation of practice nurses, both in terms of being physically isolated from colleagues within the practice during their clinical work and isolated from any nursing management structure. As one practice nurse said: 'Here you are the only nurse here at your clinic. The things that you do in your clinic you are totally accountable for.'

Another commented on how practice nurses, invariably working alone, had different levels of qualification and might take responsibility for work they were not sufficiently trained for. She stated that 'there are serious accountability problems because we're working on our own and it's not necessarily going to be that anybody is supervising…'

This comment was echoed by another nurse who said: 'I think there are accountability issues in everything we do in practice nursing because we're autonomous mostly and we're working on our own'.

She elaborated on this statement by saying that it was 'not easy' to keep asking for the opinion of a doctor. Doctors were approachable and willing to help but nurses were aware of the pressure GPs were under (pressure of work emerged as a key theme: see Section 5.2.3.3). It was felt that practice nurses were encouraged by the nature of general practice work to work independently. This might mean making decisions and carrying out treatment alone, and becoming accountable for forms of practice in which they did not always feel fully competent.

The other dimension of 'working alone' was more positive. Working alone might also mean developing expertise in a specific area of practice in a way that was highly rewarding. Nurses had more independence and autonomy than they might have had in other fields. The senior practice nurse, for instance, described nurses as

having 'their own areas of responsibility to make their own', such as taking the lead in chronic disease management.

Taking these two dimensions together, the nature of practice nurses' employment with general practitioners seemed to raise some important issues for training and development. Practice nurses had a variety of different employment histories prior to working at the practice and did not necessarily have previous general practice experience. Nurses described being trained 'in house' and taking individual responsibility for 'self-generating' training opportunities. Therefore, some nurses were trained in family planning, for example, and others were not. As one practice nurse said:

> I would like to see a standard qualification for practice nurses before they go into practice … the GPs need to know what practice nurses are able to do … it's a very woolly field and GPs don't quite know what levels of qualification nurses have when their taking them on.

Staff other than practice nurses gave very mixed impressions of whether they felt they experienced isolation or lacked the opportunities they needed to consult with others. In responding to a question about individual accountability and multidisciplinary decision-making, for example, the health visitor said: 'I think you do it [consult together] all the time, without realising or thinking too much about it that you have to, you can't work in isolation. Doing this job.'

This comment is particularly interesting as she appeared to be cut off from colleagues, at least in terms of the location of her office and as the only health visitor attached to the practice because of staff shortages. 'Working alone' therefore seems to be a subtle, or nuanced phenomenon and one that might benefit from further investigation in future.

Teamwork

The practice team had grown in recent years to nominally include staff such as members of the mental health team who were based at the practice, and the Macmillan nurse who was not practice-based but attended the clinical meetings. This expansion was seen in positive terms: as the practice administrator stated:

> … different team members have joined the team and it's actually increased the diameter of the working element … the practice functions a lot

more confidently now we've got more people that are involved within the team and the patients receive better care.

Teamwork, however, was complex, with the concept of 'team' variously used to refer to staff within the practice as a whole or a team within the practice, such as the nursing team, finance team, the 'upstairs' or finance/administration team, medical team or receptionist team. In addition, teams comprised of two or more members of staff might be set up on an ad hoc basis to complete specific projects (for example, to develop a protocol), or on a continuing basis, as in the case of the asthma team. The flexible nature of teams also meant that multiple meetings of differently constituted groups were one of the characteristics of everyday life in the practice.

In the clinical context, teamwork did not necessary mean that staff worked together in the same place at the same time. The process of care, for example, could be compartmentalised: a procedure might be divided into different elements, with the responsibility for each element handed on to the next member of staff like a baton:

> … the decision-making is split between all of us. Like giving an injection: a doctor prescribes it, he's taken part of the responsibility, the responsibility is now passed on to me…

This team-based process had implications for accountability, with accountability to colleagues re-drawn on a case-by-case basis, as Alice Kelly, the health visitor implies:

> I guess my actions would be accountable to the team as well, yes the team in which I work, because we do work quite closely on say a particular case and liase with them.

Working with differences in practice

Working in different ways to others and dealing with differences in practice were two issues that were highlighted by a number of interviewees. Doing things differently for certain individuals seemed to impact upon their work and may have even raised accountability issues. For example, one practitioner described how things might be done differently according to seniority and familiarity in the practice:

> There is not necessarily one way of doing things correctly. Some people have different ways of

doing it. A couple of nurses have been here for years, very experienced and they just turn around and … and know where to go in an emergency.

She added though that not everyone would be able to work in the same way in a crisis, and therefore procedures should be explicit and all equipment ready to hand. Similarly, knowledge about everyday practice such as dressings was not always made available to others. Rather some practitioners knew 'in their heads how things should be done'. Individual members of staff worked in different ways, used different methods of documentation and different clinical techniques, perhaps with different equipment. As a result, there was not always a clear decision trail for other staff to pick up and this could pose problems when patients were not able to see their usual practitioner.

This represented a dilemma in terms of accountability. Differences in practice, such as ways of prescribing, that provoked difficulties for other members of staff might be more difficult to address where each professional was seen as individually accountable. As one nurse said: 'They all do things differently and each individual is accountable for their own stuff. Who am I to say you've got to change it so I can understand it?'

To some extent, some differences seemed to be based on different perceptions of risk. For example, one member of staff referred to differences and risks associated with immunising children in their own home and working alone or immunising them at the practice, saying: 'I suppose what I am trying to say is different people interpret accountability differently'.

This sense that differences in practice might be partly dependent upon how people understand accountability was compounded by the possibility that there were different kinds of accountability. One GP, Richard Smith, for example, distinguished between 'administrative and organisational' accountability. Moreover, his colleague Nicholas Reynolds argued that 'clinical decision-making is at such different levels at every moment in your day', citing the effect of waiting lists, anaesthetic risks for patients needing emergency surgery, and increased paper work as examples of factors that complicated decision-making. In other words, GPs were faced not only with making decisions about diagnosis and treatment but also, in the current health care climate, had to decide which patients had greatest need, how to meet targets and so on.

Alongside this, different practitioners had different levels

of competence in different areas, differences that might not always be apparent. Enlarging on a point made earlier (in 'Working alone'), one nurse pointed out that practice nurses could be employed with different levels of qualifications. She suggests that these differences may result in practice nurses treating patients beyond their level of training, with implications for accountability:

> … many practice nurses have different levels of qualification. Some practice nurses simply have their registration as nurses and are then taken on by GPs as practice nurses and sometimes are taking on responsibilities for which they're not qualified and then there are serious accountability problems …

The guidance on boundaries offered to nurses by the UKCC/NMC was not always well-received across practice staff. For example, in talking about the UKCC's edict to prevent nurses taking verbal orders from doctors, one of the GPs considered that this was 'taking accountability to an unreasonable extreme', suggesting some dissonance between practice priorities and professional issues associated with team-working and decision-making.

In summary, although there was an acceptance of difference and individual ways of practising, particularly with respect to highly experienced members of staff, there were some negative connotations attached to deviating from standardised ways of working within the practice. As implied above, one of the issues that might have shaped this view was the accountability of practitioners, which appeared to provide a rationale for individualised practice. It might also be that attempts to reduce difference were rooted less in the practice than in general policy-driven trends towards evidence-based practice and the use of aids to standardise decisions, such as protocols.

Working in the same way

Working in the same way was generally viewed positively within the practice, with many members of staff either encouraged, or already striving, to adopt the same practices. The senior practice nurse, for example, described the differences that used to exist within the practice regarding the treatment of hypertension and how things were changed in order that staff would begin 'to think the same way'. She states:

> I had a lot of discussion with the doctors beforehand and we used the British Hypertension Society Guidelines and developed really quite a

good protocol … I think because doctors like to treat blood pressure so differently, they usually all have their own ideas on how it should be done. But we needed to really overcome that so that everybody was thinking the same way.

Protocols played a central role in standardising practice, instructing staff on how to run services such as the immunisation clinic, and how to document practice. This was the case, for example, where nurses were extending their practice. As one of the practice nurses said: 'There are certain procedures that we perform … that is more like an extended role … but to make sure everyone is doing the same thing we follow a protocol'.

Protocols shaped practice in the family planning clinic, for example: 'they have written templates, written protocols which are followed rigorously at every consultation by every doctor or nurse so everybody follows the same guidelines' (trainee practice nurse).

Indeed, the development and use of protocols and guidelines were seen as ways in which the practice became a team: As one member of staff said:

> I do feel as a practice we are all part of a team. We have protocols and policies we all do follow and guidelines we all do try to follow.

At the same time it was recognised that, as with other specialist clinics, relevant protocols required updating in order to standardise practice. Consistency and 'sameness' in ways of thinking, treating and documenting were not only equated with best practice and seen to help co-ordinate care, they were also linked to exercising accountability. As Richard Smith (GP) said:

> I think as long as we are seen to at least have systems which are acceptable across the board by all people in the same game if you like, if that is standard practice … and be seen to be trying to improve all the time, then I think our accountability would be discharged.

What was less clear was the extent to which individual GP practices across the PCT were able to sign up to the same standardising systems, although this appeared to be the vision of staff at the Market Street Practice. The business manager, for example, stated:

> I'm sure there will be individual practices who will say 'This isn't for us', but I think … you know … just give them the general guidelines so that everybody's receiving the same standard of

treatment … the standard has got to be the same.

5.2.2.4 Decision-making

Observational and interview data suggested that there were two very different forms of decision-making within the practice, influenced by different considerations.

Decisions regarding clinical practice

Several participants referred to the many different levels at which clinical decision-making took place. One of the partners, for example, described the thinking that accompanied starting a patient on a long-term anti-depressant: 'I've got to think of side-effects, clinical efficacy, cost-effectiveness, long-term price, in just one decision'.

Within clinical practice, where decisions were made about individual patients, there were clear indications of multidisciplinary, and at times interdisciplinary collaboration (see footnote 1, Section 1.2.1 for clarification of this distinction) grounded in respect for colleagues' knowledge and skills. These decisions, apart from drawing on clinical experience and judgement, were also shaped by guidance in the form of templates, protocols and sources such as the British National Formulary (BNF).

Templates represented a computerised, tick-box system available during patient consultations that prompted staff to check certain information with a patient, such as family history, or to carry out certain investigations, such as blood pressure or peak flow readings. Each template was part of a broader practice protocol, developed from a range of sources of evidence including national guidelines, as well as through discussions among practice staff.

Practitioners spoke of using sources such as the BNF and drug information leaflets to ensure appropriate choice and administration of medication, either in terms of their own practice or for double-checking decisions where they were working alongside colleagues. Vicky Gardener, one of the practice nurses, for example, described consulting the BNF when she was responsible for the administration of medication that had been prescribed by one of the GPs, saying :

> the responsibility is now passed on to me to make sure I give it in the correct manner and I have to point out to him, 'Oh, the BNF says he should only be having this every two weeks'.

Implicit in a number of practitioners' comments was a sense of insecurity, of problems or potential errors waiting to happen, that was countered by the use of such sources. A practice nurse said, for instance:

> It takes me so long if I do the baby clinic or anything, because I'm checking the things. I know I've checked them umpteen times but I'll check it again and check it again.

Clearly, this heavy reliance on information to back practice was time consuming and contributed to the pressures that staff were already experiencing. One practice nurse, for example, in describing the need to refer to drug information leaflets, implied that the process was like so many hurdles in a race, requiring practitioners to: 'get the leaflet out, read it, read what side effects are, read and see the patient is getting appropriate advice …'

At the same time, forms of guidance such as protocols were largely welcome. One nurse, for example, described the guidance written by a fellow practice nurse and available on the practice computer as 'a lovely, wonderful protocol'. It seemed that the protocol both provided a way of framing safe practice and a more convenient source of reference than the BNF, although not without problems (as discussed in 'Working the same way').

Members of staff were not solely reliant on written sources of guidance but also sought information and opinion from colleagues both within and outside the practice. One practice nurse, for example, described looking for support and confirmation from one of the practice partners:

> If I'm ever worried about anything I always go and refer to the GP… (they're in charge really) … I would much rather know I could go and see one of the GP's and just – even though maybe I'm suggesting [the answer] – I just like to have it confirmed.

A community staff member, Angela Jones, echoed this form of checking and making sure. She explained how she sought confirmation from staff at the local hospice, Highgate House, for decisions about medication for patients who were terminally ill: ' … I know that I always do go to for advice – very often before I come to the GP – to Whitborough House to see if what I'm saying is right'.

In some instances it appeared that nurses were referring to colleagues to check out decisions that they had, in effect, already made. Incidents during fieldwork, for

example, suggested that, although nurses might ask the opinion of GPs, they were often confident in their views and were asking for an endorsement of their decisions, rather than asking GPs to make decisions on their behalf. It was not clear if this process was linked to the current nature of primary care and represented, for example, a response to clinical governance. Alternatively it might equally be understood as a contemporary version of the traditional 'doctor–nurse game' in which doctors might be given the facts about a patient in order to make a decision, but the nurse relays the facts in a way that directs doctors towards some decisions rather than others. This impression, if there is any truth in it, is interesting, especially in the context of a practice structured by the principle of consensus decision-making, and might suggest the resilience of traditional systems, boundaries and ways of working.

There were clearly some areas of practice where consulting with colleagues became particularly significant, partly because of the issues these might raise about accountability. Alice Kelly, the health visitor, for example, describes how she would refer to others when working with children at risk:

> … we are accountable for our actions and we do have a duty to protect the child – all children – so if we have any concerns about how the child is being treated then it is our job to take action on that. And we cannot ignore it and say 'Well let's see how it goes for a couple of months': we need to discuss it with others and find out if anyone else has any concerns.

Non-clinical decisions

In other areas of decision-making, notably decisions concerning populations (associated, for example, with the development of protocols) or practice-related decisions (such as whether or not to develop new services such as the pharmacy, or to set up new specialist clinics), decision-making was rather different in nature.

Numerous discussions of decision-making during fieldwork suggested that individuals were given the freedom to work on specific health care or practice issues on behalf of the practice, such as the development of protocols, for which a broader group (such as the clinicians) accepted responsibility. However, closer inspection of the decision-making process suggests that individuals brought this work back to all practice partners at some point for discussion.

The clearest example of this process concerned the rather lengthy process for deciding on new practice initiatives or developments. Potential new developments could be proposed by any member of staff and argued for at weekly partners' meetings. To try to ensure consensus, the protagonist needed to present a sound business case, make judicious use of knowledge about other members of staff and the positions they might adopt, employ good negotiating skills and carry out a certain amount of lobbying before the meeting. As one member of staff explained:

> First of all you get to know whether they (the partners) are likely to agree with you or not, so if you want to make a certain proposal … you either collar them before hand or if you are in a meeting or something smaller you would talk to them rather than anyone else.

However, another member of staff, who put in long hours to prepare for a meeting, described how consensual decision-making might be shaped by careful planning, but it was ultimately informed by the practice partners who, understandably, as associates in what was essentially a small business, held the greatest sway:

> Being familiar with them, you always go in for the kill … you always dig for gold and come up with silver 'cause at the end of the day it's their partnership, it's their money that's being spent.

Significantly, the acceptance of consensual decision-making rather than, say, a majority vote, was written into the partners' contracts. However, although a consensus needed to be reached between partners for a decision to be passed, the senior partner, who also managed the practice finances, appeared to have a high profile in decision-making while newer partners played a lesser role during discussions.

5.2.2.5 Documenting decisions

During interviews, staff implied that accountability was associated with both deliberate action and deliberate inaction. As one nurse said during a discussion of accountability, 'if it's something that I think it's not my reame, I won't do it'. Where action was taken, and sometimes when deliberately not taken, this – at least ideally – went hand in hand with providing a written account, generally on computer. However, writing an account, or the type of account written, was influenced by a number of factors, notably the nature of computer

software, individual propensities, and a perceived need for defensive practice.

The use of computers

Most practitioners used computers to record patient care. However, unlike the old patient record scheme, the format for computer records dictated the way in which notes could be written up. The software used a template that, for the most part, encouraged the documentation of medical issues at the expense of space to record other aspects of care. For example, one practice nurse commented:

> …trying to follow care and treatment of patients I find … because things are not documented as easily as on paper, I find that area a little difficult and worry and wonder if I will make a mistake.

She outlined the way in which absence of information about a patient's care might hamper the delivery of appropriate treatment at their next visit, saying:

> I am finding on computers … people are just writing 'dressing changed' on computers … I've not done it before, never done it and I don't know what sort of dressing they are doing.

Individual propensities

However, although computers were seen to influence the thoroughness of documentation, this influence was not straightforwardly associated with the nature of the computer programme. Some staff recognised that, despite trying, they did not give enough attention to documentation. One district nurse said, for example: '… I know I'm not always good at it, at documenting things. I do try very hard.'

Up to a point, the extent to which activities were documented reflected the time practitioners had to give to this. However, time was not the only factor influencing the practice of documentation. For example, in noting that each person was personally responsible for documenting their care, one practice nurse observed that individuals vary in how much they chose to record.

This was also suggested through fieldwork. One particular day, the practice nurse was very busy. A patient was waiting in the consulting room for a dressing to be renewed and the nurse was trying to find information about the previous condition of the wound and the kind of dressing applied. Unable to find any information on computer, she decided on how to dress the wound partly through questioning the patient and

partly through attempting to identify what was on the old dressing when she removed it. She then took time to record a description of the wound site and the dressing she had applied. Interestingly, the nurse considered that, in the context of a busy surgery, her documentation verged on 'the extreme'. However, her attention to recording practice may have been influenced by her understanding that, in other contexts such as the care of pressure ulcers, nurses who failed to record the condition of the patient's skin were at risk of litigation. This was one of a number of concerns that participants raised about their accountability.

5.3 Concerns about accountability

Data from interviews indicated that most members of the practice's staff were concerned about the nature and extent of their accountability. Some concerns were specific to nurses and health visitors, while others were relevant to colleagues within the practice as a whole.

These concerns about accountability took a number of forms. Some interviewees had particular concerns associated with particular areas of practice, such as immunisation and family planning. Many problems were intensified by working under pressure. Problems were also identified in relation to the use of protocols. Staff raised issues about accountability in relation to documentation and the recording of practice, particularly in relation to defensive practice. These concerns, articulated during interviews, were also evident on a regular basis through fieldwork. Data from both interviews and observation will be presented as relevant.

5.3.1 Problematic areas of practice

Some areas of practice appeared to raise more accountability issues than others. The most commonly mentioned areas of practice – particularly by nurses – concerned injections (particularly the administration of vaccinations), medications and family planning.

5.3.1.1 Injections and vaccinations
During fieldwork, staff frequently raised concerns about

the administration of injections and vaccinations. There was a sense of dread that a patient might suffer an allergic reaction following vaccination. One nurse spoke of anxieties about giving injections and medication that were unfamiliar. It was difficult to read all relevant information on a drug prior to its administration in the face of pressure to avoid running late during a clinic. Moreover, it seemed that the need for information was endless. For example, despite an educational session on vaccinations, practice nurses still considered that they had insufficient information about certain vaccinations and needed more detail from visiting drug representatives. Similarly, although nurses were involved in writing the practice protocol for vaccinations, it was difficult to ensure that protocols were kept up to date

Several practice nurses talked about how their uncertainty about immunisations and similar procedures, such as giving injections, heightened their awareness of accountability/responsibility. One nurse stated, for example:

> I am giving a lot of injections – one day somebody is going to have an anaphylactic reaction, how am I going to deal with this? I will be responsible for what happens.

She understands her accountability in individual terms, saying : 'I am accountable if anything goes wrong. I am the first line to do something about it.'

This sense of accountability appeared to have impelled her to seek out educational opportunities and to take an active role in ensuring the appropriate emergency equipment was available. However, not all concerns about giving injections could be dealt with so straightforwardly. Another practice nurse tells of the same concern about giving injections. However, these are heightened by the risks posed by working with children, and her infrequent practice:

> … I worry about vaccinations, probably more than anything else, giving people injections, and things, especially children. And it probably gets worse for me, worrying about children, giving children injections, because I do so little.

This nurse was not alone in her anxiety about immunisations – others also described how these were associated with working under pressure or working without support. Yet she did find the use of protocols helpful:

> But now Vicky [practice nurse] has gotten it all in the computer and she's written a lovely, wonderful protocol. It's all written down, all the up to date information, so I feel much happier about it now because she's got a nice file that you can refer to.

5.3.1.2 Medications

The issue of medications or drugs in the practice also raised concerns about accountability for a broad spectrum of staff. The complexity of decision-making about medication has already been outlined (see Section 5.2.2.4).

To make matters more complex, there was not always enough easily accessible information, particularly about specific patients, to ensure appropriate administration of drugs. During fieldwork, for example, it was observed on several occasions that practice nurses were unable to find records on the computer about a patient's treatment and medication schedule.

The complexity of this area was increased by the shared nature of decision-making about medication and the way in which decision-making was often a process rather than a single event in which accountability seemed to pass from one practitioner to another at different stages. For example, one of the practice nurses, Vicky, described how:

> The decision-making is split between all of us. Like giving an injection – a doctor prescribes it, he's taken that part of the responsibility, the responsibility is now passed on to me to make sure I give it in the correct manner and I have to point out to him 'Oh the BNF says he should only be having this every two weeks'.

In other words, the GP is seen to be accountable for the initial decision regarding prescription, but the nurse is thought to become accountable for carrying out this decision, and this accountability is thought to require her to check on the GP's decision.

This suggests that an individual's accountability may require them to step beyond conventional role boundaries. Rather differently, expanded roles raised doubts about the location of accountability. Angela, the district nurse, for example, described how she might 'take the lead' in managing the pain of a patient who was terminally ill but questioned whether she was overstepping the boundaries of appropriate practice:

When you're putting in a syringe driver you probably know, the doctor will say, 'Well what do you want in it?' and you do say and then you sit back well and say, 'Is this right, is that what the patient really needs?' But I think, the GPs here in particular, we've got the experience and the knowledge and we do very much … we take a lot on board with the terminally ill and medication.

This practitioner supported her decision-making, not only by referring to one of the GPs but also by drawing on advice from colleagues in a local hospice. However, despite taking the lead, she implied a level of uncertainty, particularly concerning her decision-making and her accountability.

The role of the practice in dispensing as well as prescribing medication proved a further area of concern about accountability for staff. One member of staff who previously worked on reception and moved to work in the practice dispensary, described a potential error related to the previous dispensing system. She told of an occasion in which there was confusion about two sorts of medication:

> … two very different drugs and yet they were in boxes exactly the same colour, they're both the same strength, you know, they both were 5 mg, and a mistake was nearly made.

This member of staff suggested it would be 'dreadful' if she made an error, and would keep her awake at night. At the same time, she thought that, in the case of a mistake, the doctor would take ultimate responsibility for this. During fieldwork the pharmacy in the practice was undergoing a considerable amount of change. The practice administrator, Cheryl Henderson described the situation in the following terms:

> … for the last couple of months we've all been learning together so it's been trial and error who's been doing it correctly and who hasn't … which slows down the working process … the work's still being created so you've got an enormous backlog of work which creates the stress … it's been tremendously stressful down there recently.

As a result of a request from Cheryl, the partners at the practice agreed to employ two more staff for pharmacy

5.3.1.3 Family planning

Interviewees also identified family planning as a significant area of practice that raised concerns about

accountability. The specialty of family planning was broad in scope, ranging, for example, from emergency contraception to under-age pregnancy and involved staff in complex and difficult decision-making.

This area of practice also varied tremendously for nursing staff, depending on the competencies that they had developed. One nurse, for example, had been trained to carry out pelvic examinations when taking cervical smears and was willing to take accountability for her 'extended practice'. Another nurse sought out family planning training in order to be able to prescribe emergency contraception, while one nurse who was not family planning trained would only follow the protocol for family planning and then consult with a doctor.

The nature of family planning work tended to make staff aware of their accountability, which in turn influenced the way they practised. One practice nurse, for example, pointed out the dilemmas raised by the issue of emergency contraception and how nurses' lack of power to prescribe meant that they might have to chose between the needs of patients and their own vulnerability to potential litigation. Generally, although a patient requiring emergency contraception might be seen by a nurse, treatment and prescriptions had to be agreed and signed by a GP, unless the nurse was family planning trained and could work according to the Patient Group Directive (PGD). The PGD allowed them, not to prescribe but to give a medication without GP involvement. However, according to this practice nurse, if a GP was unavailable, she might act without authorisation despite lack of special training, where this was in the best interests of the patient:

> … I would possibly, if I couldn't get hold of a doctor, actually give it and then speak to a doctor afterwards to say that I had and to ask them to sign a prescription. So that does leave an accountability issue there but I think it may be, particularly if it were a teenager, better to give and to think about it afterwards than to wait and ask somebody to come back.

Here, the nurse suggested that her accountability to the patient, who she feared might not return and might then face an unwanted pregnancy, took precedence over other concerns, such as approved practice procedure. However, her decision was informed to some extent by the fact that she had carried out training in family planning practice. Another practice nurse, not trained in family planning nursing, took a very different stance and stated

that she would follow the protocol and not provide treatment in the absence of a GP.

Because of this kind of dilemma, one nurse thought that her accountability extended to ensuring that she was trained in family planning, so that she could prescribe:

> … you find out what you are lacking in, what you need to know more about and what you are accountable for … We provide emergency contraception, I didn't know enough about it and it would help some of my patients if I could prescribe that, so I expressed an interest to the senior practice nurse.

As a result, she attended a family planning course and was then able to help her patients and prescribe emergency contraception under a PGD.

This family planning theme highlighted the differences in nurses' practice, depending upon their level of training. At the same time, it gave some indication of the way in which accountability related not only to practitioners' actions, but deliberate non-action, both of which raised issues about documentation.

5.3.2 Documentation

Nurses in particular spoke of their concern about the implications of a lack of documentation and, conversely, how they practised defensively, including the use of extensive documentation, to 'cover' themselves when there was any uncertainty about their practice.

One practice nurse provided an example of concerns about accountability where documentation was missing, this time in the context of repeat prescriptions by saying:

> There are quite a lot of areas…not necessarily being able to find evidence that the medication is to be given in the patient's notes or on the computer … but giving it because somebody says… previous people have said that it's to be given.

She suggests that, without appropriate documentation, staff might accept 'word of mouth' as a basis for giving medication. Indeed, during fieldwork, a practice nurse was observed giving a vitamin B12 injection after not being able to find evidence of a prescription filed on computer. The nurse discussed her decision after the clinic and said that she was willing to take responsibility for her decision, arguing that she 'would not have given it

if it were anything other than a vitamin'. She added that her decision was shaped by the fact that, according to the clinic list, administration of Vitamin B12 was the reason for the patient's visit, and the patient confirmed receiving this treatment regularly and that the last occasion was two months ago. This nurse knew that giving the injection without evidence of prescription left her vulnerable to litigation but that pragmatic considerations intervened. Moreover, this 'happened all the time'.

Although documentation might be given variable attention in everyday practice, it took on additional significance where it was feared that something might go wrong, or where a practitioner could not control events or the actions of others. One practice nurse, for example, described an incident in which a patient who was attending for a blood test said she had nearly collapsed the previous day. In response, the nurse suggested that she should make an appointment to see a doctor. However, the patient only wished to see a female doctor, and when no female appeared to be available (a computer error), she declined an appointment with an alternative male doctor and left the surgery. When the nurse learnt of this, she was worried:

> … because although I'd said to her [to see a doctor], I hadn't actually written anything down on the computer to say I'd said all this. And I thought afterwards … so I did go back and put it on the computer then, because I thought that would be awful then if she then was taken ill.

Given the retrospective nature of this account, it could not be written in the patient's notes, but was recorded separately. It demonstrates how practitioners live looking over their shoulder, to the extent that what becomes 'awful' is not only that the patient may become ill, but that practitioners may face punitive action if they do so.

5.3.3 Working under pressure

As suggested earlier, working under pressure, either through time constraints or volume of work, became an important theme within the data. Some of this pressure was seen to be externally generated. For instance, one GP referred to what was, at the time, the UKCC's restriction preventing nurses from taking verbal orders as a 'rule from on high' that not only put pressure on doctors at the practice but also on community hospital nurses.

Some of the pressure staff experienced was linked to the changing nature of general practice and primary care in

which broader responsibilities were not matched by an increase in resources. For example, one of the partners stated:

> It seems as if more and more and more is coming in, not necessarily clinical but just … there seems to be so many things happening and just the same number of GPs. It seems to be spiralling completely out of control.

These changes were matched by increased demand from patients, who were putting increased pressure on everyday practice. One of the practice nurses gave the impression of the surgery as a hydraulic system in which pressure passed from one point to another:

> Our consultations always seem to run over the allotted 10 minutes, [so you get] more than one patient in a 10-minute slot, the receptionists get busy and need to put an extra patient in and get pressure from patients, and pressure comes up to the treatment room …

Pressure was experienced within the practice across all levels of staff, with several participants indicating how any delay in one part of the practice had knock-on effects throughout the system. Christine Rye, one of the receptionists, spoke of this in terms of fearing to make the wrong decision or 'dropping the ball' when dealing with numerous things at once, with the implication that this would create difficulties for the way that the practice functioned.

It was widely thought that, over recent years, there was less time to concentrate on developing skills or treating patients, and practice nurses in particular expressed concern that pressure and general shortage of time might have an impact on standards of practice. For example, one practice nurse described the 'temptation' to give treatment quickly, rather than familiarising herself with the side effects and the appropriateness of treatment. As she states, 'I am scared one day I am going to trip up on that'.

Similarly, another practice nurse outlined her concerns about the provision of travel advice when there was insufficient time: 'You've only maybe sometimes five minutes, maybe ten minutes, to talk to them and that's when it gets a bit worrying'.

One nurse made a direct connection between this relentless pressure and accountability. She noted that the pressure not to run late tended to influence the quality of care provided by discouraging nurses from entering into

an exploratory dialogue with patients, or to work proactively:

> It's all so easy to say well I'm really much too busy to deal with this today, um and I won't ask about these various problems. I'll pretend they're not existing ...I think how far you go is very much up to you and that's where I think your accountability comes in.

It appeared that shortage of time prompted nurses to provide only the minimum care that could be expected, the minimum standard for which they were professionally or legally accountable. In other circumstances, however, they would wish to discharge a moral accountability to the patient by offering a different standard of care in which they opened up the possibilities of the clinical encounter through a more proactive approach. Put crudely, this could be the difference between simply following a protocol and asking additional questions prompted by the practitioner's intuition about a particular patient's needs.

5.3.4 Referring to guidance

It has already been identified that protocols were seen by practice staff to be of value at least in some circumstances. Participants did however raise concerns over the use of protocols concerning a) their adequacy and b) their legal status.

5.3.4.1 The adequacy of guidance

Decision support technologies such as templates and protocols were recognised as useful and reassuring, partly because they were based on research evidence, agreed by experts and practice staff and considered up to date. However, some practitioners felt it was inevitable that guidance protocols were not entirely clear in the guidance they offered, while others recognised that they did not necessary represent a complete solution to any clinical problem. Sarah Watson, for example, recognised that the 'oral contraception' template mentioned above played a useful role in decision-making, but knew that there was certain information that it did not provide. One participant suggested that, where information was insufficient, staff could refer to relevant colleagues. However, it was not clear how staff could know when (or what) information was missing. A distinction was drawn between nationally or externally developed guidelines and internal or local protocols, and the gaps in

knowledge within local protocols were linked by some to the ways in which protocols were written. Protocols developed within the practice were ideally developed by those members of staff with the most expertise in the field, or by volunteers who, through developing a protocol with other staff, gained expertise in the area. Vicky Gardener, a practice nurse, for example, talked about the process that occurred when she was asked to write a protocol for vaccinations, that included searching the Internet, consulting with other practices and then seeking help within the practice from other members of staff.

However, other staff were not able to contribute to this process on all occasions. One of the GPs for example, said of the development of one protocol: ' I suppose the way we did that was I wrote a draft protocol and that was me and in a way I am not terribly sure that is the best way of doing it'. Although this protocol was subsequently discussed and modified by a wider group, he felt that the final protocol was inevitably shaped by the nature of the first draft and he felt that involvement of others from the outset was preferable.

5.3.4.2 The legal status of guidance

The issue of adequacy was also linked to the legal status of protocols and similar guidance. Just as some guidance had gaps in information that clinicians might have difficulty in identifying, it was also difficult for staff to know when guidance had become out of date.

The use of appropriate guidance also seemed to pose a problem. For example, during the study it became lawful for prescription-only medicines such as travel vaccines and immunisations to be administered by nurses in line with a patient group directive. In this instance, nurses were technically dispensing medications according to an ongoing prescription signed by GPs, rather than prescribing *per se.* However, there was a degree of confusion in this area and some indication that a number of staff had been working to a protocol rather than a PCG for guidance in administering travel vaccines. One nurse described this as 'frightening': 'because that is law, written down that you should not be giving these injections without a patient group directive'.

5.4 Summary

 This chapter provides the findings from interviews, the use of vignettes and participant observation. Findings relate to three broad areas: the ways in which accountability was understood in theory, the way accountability related to practice, and the issues and concerns raised by accountability.

First, most participants were unsure about the meaning of accountability. This was either because the term was being used in a way that seemed new, because the meaning depended on the group to whom a practitioner was accountable (for example, accountability to the patient was different from accountability to a professional body) or because it overlapped to some extent with the concept of responsibility. For some it had a punitive air, for others it was a way of describing relationships to colleagues or others, but overall, accountability had an increasing presence, if not oppressiveness. This linked with the way that a number of practitioners spoke of the multidirectional nature of their accountabilities.

 Second, looking at accountability in practice, responses to the vignettes suggested that there was widely varying interpretation of the location of accountability. Although some participants stated that all practitioners are accountable for their actions, others suggested that, in specific contexts, some practitioners may be more accountable than others or might share accountability. It was also indicated that the accountability of an individual practitioner could vary in the presence of different colleagues and that accountability could be correlated to clinical experience or previous knowledge of a particular patient. There was some suggestion that nurses might have different kinds of accountabilities compared to doctors, or that the accountability of nurses was more circumscribed by the growing use of protocols that facilitated their extended role, in comparison with GPs, for whom there seemed no bounds to their accountability.

 Third, regarding concerns about practice, the issue of accountability particularly came to the fore for practice nurses who spent much of their time 'working alone' – a term that suggested both autonomy and isolation. There were areas of practice where working alone raised particular concerns, such as family planning, vaccinations and some medications, areas previously understood as 'medical'. Here protocols and similar guidance such as national patient directions (NPDs) were seen as helpful as ways of providing a framework for safe practice and a way of working more quickly. However, such guidance also raised issues about accountability. There was concern on the part of some

staff that the wrong guidance was in use (for example, protocols rather than NPDs). In addition, there was anxiety that the knowledge on which protocols were based was obscured and possibly out of date. Moreover, the knowledge that underpinned protocols did not always fit with clinical judgement, and staff were unsure how to respond to this dissonance.

In contrast to working alone, teamwork existed predominantly as the involvement of different practitioners in a specific area of work over time, such as protocol development or patient treatment, rather than as an activity that integrated the views or actions of members of the multidisciplinary team at any one time. The catch-all phrase of 'multidisciplinary decision-making' tends to conceal this sequential process and the individual decision-making it involved .

6. Discussion

This section of the report continues to explore the findings of the study under the three main themes that emerged from the data: understandings of accountability; accountability in practice; and concerns about accountability. Within each of these areas, findings are considered in relation to issues raised through a review of the literature.

6.1 Understandings of accountability

The varying and ambiguous way in which accountability was understood by participants tends to mirror the literature on accountability: reference was made earlier (in Section 2.1) to Hunt's (1994) portrayal of accountability as numerous, different animals going under the same name (rather than accountability as a single beast of various parts). Despite frequent reference to accountability in current policy, it is widely recognised that the concept largely resists definition or is tautological (Tingle 1995). However, findings from the study suggest a number of features currently associated with accountability.

First, accountability seemed to mean different things to different people. One of the main differences is reminiscent of the distinction drawn by Lewis and Batey (1982), who suggest that accountability can either be understood as a 'recounting' or a retrospective and defensive attempt to explain actions, or a systematic disclosure of those things that an individual is answerable for. Data from the vignettes, for example, suggested that accountability was understood by some in terms of apportioning or accepting blame. Significantly, this understanding sits uneasily with the clinical governance literature that promotes a blame-free culture. Understanding of accountability as systematic disclosure was less evident, but some participants suggested accountability was more of an imperative, something that spurred action and facilitated being able to give an account, rather than something to be determined retrospectively (see Section 5.1.2.1). While accountability was often referred to as being prepared to 'carry the can' for actions and

omissions in practice, it could also provide a way of describing a practitioner's relationship to a range of other individuals or groups, such as the members of a health authority, partners, colleagues or patients.

In addition to differing interpretations of the concept, the location of accountability seemed to be differently understood by different participants. The vignettes were particularly informative in highlighting how practitioners attributed accountability differently when discussing the same clinical scenario. To some extent these different understandings of accountability – such as the trend to see doctors, and particularly partners as more accountable than other practitioners – may reflect the histories, priorities and preoccupations of different health care professions, but the study was too small to explore this possibility.

The second feature found associated with accountability is closely linked to the first – its polysemous nature. Participants found it hugely difficult to articulate what accountability meant and the more intent they became on pinning it down, the more its meaning seemed to elude them. One reason for this is that, not only do multiple meanings of it exist but, as Ferlie et al. (1996) found, they can coexist. Its meaning is therefore unstable and shifts from one scenario to another. For example, in line with the edicts of the NMC, practice nurses could understand themselves to be accountable for their actions but, at the same time, might attribute accountability to a medical colleague where it was thought that he or she had better knowledge of a patient (see Section 5.2.1.2).

Significantly, this kind of shift in meaning has also been observed beyond the clinical domain. Accountability appears to be what Charlton (2000) has described as a 'pinch-me' word – a word used in managerial or policy discourses that has both everyday and technical meanings that can be strategically switched. Charlton uses the word 'quality' as an example, suggesting that, in its everyday meaning, quality broadly relates to excellence and, by implication, 'quality assurance' seems a desirable goal. Yet, in managerial discourse, 'Quality Assurance is a technical term for a specific system of management (i.e. the audit of systems and processes instead of outcomes' (Charlton 2000: 608). Although there is no inevitable relationship between this and the everyday meaning of quality, Quality Assurance tends to connote excellence. Similarly, the meanings of accountability seemed to become switched, one for another. For example, in policy discourse, accountability

has not been clearly defined but implies 'being able to provide an account' as well as 'being responsible for'. It is arguable that the emphasis on accountability preys on an implicit understanding of accountability as being culpable, a point recognised by Hunt (1997: 524), who suggests it is important to remember that 'Accountability comes before culpability … Being brought before a disciplinary board is not itself an act of discipline'. The switching of accountability's meanings in the policy literature may have contributed to the polysemous understanding of accountability held by practitioners in the study.

At the same time, the ambiguous, polysemic and 'pinch-me' nature of accountability suggests that it might be productive to consider it less as a word that can be defined, and more as an example of a classificatory concept. This kind of concept has been described by Bloch (1990: 185) as an 'essential building block of culture' derived from 'loose and implicit pratical-cum-theoretical pattern networks of knowledge', which has no inevitable connection with language. Thus, in their reference to accountability, clinical governance policy and professional bodies such as the UKCC/NMC are possibly tapping into a rather amorphous but highly charged complex of meanings that have a much broader cultural resonance, with ethical, moral and emotional connotations. Accountability is to some extent concerned with the obligation to disclose aspects of practice and to accept the consequences of disclosure (Duff 1995), including obligations applied from outside (for example as required by policy-makers or professional bodies). At the same time, however, the study suggests that a different and perhaps more pervasive form of accountability coexists with this, namely accountability as a kind of spectre at the clinician's shoulder or as an inner supervisor, monitoring practice. This is different to the notion of blame. Rather, the distinction between external and internal forms of accountability suggested by the study shares similarities with one drawn by Lewis and Batey (1982: 10). They distinguish between structural accountability (made concrete by the pattern of disclosures that might be owed) and attitudinal accountability (accountability as an internalised disposition, or 'perceptual predisposition', existing independently of organisational realities). The distinction is also reminiscent of the two separate paths Shapiro (1998: 296) identifies in modernisation policy. One path is that of clinical accountability (or 'a welcome return to professional values in an age of deepening

mistrust of professionalism'). The other is a web-like accountability framework, spun by health authorities, PCTs, the Commission for Health Improvement (CHI) and similar bodies who are poised to act when performance is considered not good enough.

The possibility that the meaning/s of accountability are being influenced by current health care policy and the modernisation literature is linked to the third feature identified to be associated with accountability, namely that accountability is in some way something new. Accountability was seen to have become central to decisions about the use of resources, and to aspects of practice, such as the nature and reliability of documentation. Historically, as suggested earlier, accountability may have been more of a preoccupation for some groups of professionals than others. What is new to all groups, however, is the form (or forms) of accountability demanded by clinical governance, and its omnipresence. The study suggests that individual practitioners are seen to be accountable to a considerable number of groups or agencies, such as patients, colleagues, employers, professional bodies, and the government (again, Lewis and Batey's (1982) concept of structural accountability, that might otherwise be described as lines of accountability). The processes for disclosure (such as how local practice was made available to inspection or complied with nationally agreed standards) are less obvious (see Section 2.3.1).

6.2 Accountability in practice

The study suggested considerable confusion about clinicians' accountability in practice. As suggested earlier, data from vignettes in particular indicated that there was considerable variation in views about the location of accountability in practice, and a conflation of professional accountability with that due to an employer. Some participants accepted accountability for their own practice in most circumstances, others – especially non-medical staff – saw accountability for their practice rested much more with others. There was similar variation in understandings about where responsibility lay for ensuring adequate training or preparation for any new area of practice: some participants felt that practice partners were accountable for ensuring provision while others, for example, some nurses, thought that they were accountable for ensuring their own competence.

These rather incongruent statements about the location of accountability can be partly understood through the extent to which they mirror differences in the statements issued by the regulatory bodies of nursing and medicine. The position of the UKCC (1992b) assumes a high degree of nursing autonomy that is at odds with both the General Medical Council's (GMC 1995) statement on the professional duties of doctors and the British Medical Association's (BMA 1996) document which offers guidelines on medical procedures performed by non-medical health professionals (Tingle 1997). GMC guidance, for example, instructs doctors: 'You must not enable anyone who is not registered with the GMC to carry out tasks that require the knowledge and skills of a doctor' (GMC 1996: Clause 29).

Delegation is possible, but only if doctors have assured themselves that those to whom they entrust work are competent. Medical guidance therefore assumes that it is doctors who are in overall control of treatment and care, and who retain clinical responsibility for the actions of those they delegate to. In contrast, nursing guidance, such as the UKCC's *The Scope of Professional Practice* (UKKC 1992b), states that it is nurses who have to ensure, on an individual basis, that they are competent to undertake new roles or tasks.

Confusion over accountability had legal as well as professional implications. A few participants, for instance, suggested that some practitioners could be more accountable than others on the basis that they had more experience. One example of this was the proposal that doctors and nurses had different fields of practice (the treatment of leg ulcers, for example, was seen as a nursing intervention) and were accountable for their actions when working within those fields, but not beyond them. Yet the argument about greater experience did not only relate to the expertise associated with different professions. It was thought possible that practitioners with more expertise than colleagues in the same profession could be more accountable, a view akin to Bergman's (1981) degrees of accountability. This understanding is evident, for example, in statements about doctors' accountability in the vignette dealing with the care of a patient with heart disease. This 'staggered' form of accountability has some legal recognition. According to the Bolam principle, (see Section 2.5.4) a practitioner needs to exercise the skill expected of any ordinary, competent person in the same role. Those who profess to be trained in and practice a

specialty, and thus have additional expertise (such as nurse practitioners), are regarded differently in the eyes of the law than practitioners who do not make such claims (Pennels 1998). Case precedent shows, however, that where a role is expanded, the standard of care expected is that associated with the post and not the person holding the job. Thus, if a nurse is in a post previously held by a doctor, the standard of care required would be that of a doctor and not a nurse (Tingle 1998).

One interesting issue concerning accountability to emerge from the study concerned teamwork. As discussed earlier, clinical governance places considerable emphasis on teamwork, including greater use of multidisciplinary decision-making as a means of auditing and improving standards of care. What emerged from the study was that teamwork and accountability had different meanings in the different domains of a) clinical practice and b) the practice.

In clinical practice, there was a considerable amount of respect for the skills and expertise of colleagues. However, the nature of practice was such that decisions were not often made as a team. For example, in line with earlier research findings (Mackereth 1995), practice nurses worked largely independently, drawing on protocols and occasionally seeking further opinion. This suggests, ironically, that a significant component of modernisation, namely working to protocols to ensure evidence-based practice, may run counter to another modernisation priority, multidisciplinary working. Where decisions were not made by an individual practitioner, they tended to involve different members of the practice team at different stages of decision-making, instead of emerging from concurrent discussion and negotiation between clinicians as a collective. For example, a GP might prescribe a course of injections for a patient, which were then administered by one or more of the practice nurses. The administration of each injection meant revisiting the original decision – whether, for example, the dosage was right, or the medication was contraindicated by other treatments. This kind of 'teamwork' was taking place before the introduction of clinical governance and appeared largely unchanged by clinical governance. Significantly, in terms of legal accountability, this sequential form of decision-making may pose fewer problems than true multidisciplinary decision-making. The law does not recognise a concept of team liability and practitioners cannot use the argument that other

members of their team told them to do something as a defence against liability: 'all [qualified] individuals within a team are personally and professionally accountable' (Glover 1999b: 7).

Different kinds of decisions were made in the practice domain. These decisions either concerned the care of groups (such as patients with asthma) and general guidance for treatment (for example, the development of appropriate protocols) or the running of the Market Street Practice (such as which new services might be developed). These decisions were where the aims of clinical governance could be seen in action most clearly, drawing in different members of the practice staff to work together on specific projects. However, the teamwork that this involved was not necessarily multidisciplinary. For example, although staff from across the practice were encouraged to participate, the kinds of evidence drawn upon to develop protocols was determined by a particular framework that tended to exclude non-medical knowledge. This is a point relevant to protocol development generally, and not specific to this practice. In addition, the nature of decision-making was shaped by the fact that the practice was a small business run by the partners. Inevitably, many decisions (particularly those with financial repercussions) were made only by the partners, even though they might potentially have implications for the way that other staff carried out their clinical work. There was therefore a rather uncomfortable fit between the demands of clinical governance and the demands of general practice.

The position of nurses in this study, especially practice nurses, was found to be particularly complex, both with regard to the lines and scope of their accountability. To an outsider, especially because of their coexisting and potentially conflicting line accountabilities to the patient, their professional body and their (medical) employer (particularly in the absence of a formal nursing line management structure), they appeared caught in a web of different priorities, interests and influences. However, this seemed to give them less concern than the scope of their accountability, particularly when working in 'grey areas' or working in extended roles, for example when they carried out such 'medical' procedures as ECG monitoring, or gave emergency contraception.

A number of recommendations have been made by Dowling et al. (1996) in relation to the introduction of new clinical roles that blur the boundary between

nursing and medicine (see Section 2.5.3). These include staff having access to legal advice and support; employers (and relevant insurers) formally recognising changes in practice; and nursing and medical regulatory bodies working together to ensure consistency in their directives. These suggestions are all endorsed by the findings of this study. In addition, the research has raised a further issue associated with protocols.

There is no national standard or catalogue that describes extended nursing roles, and practice differs, not only from one trust to another, but even within trusts (Tingle 1998). Instead, the current emphasis is on individual nurses making their own decisions as to whether they can take on an extended role. One implication of this is that employers, in order to provide full employee liability cover, have to approve any enhancement of the nurse's role as well as providing relevant training and endorsing any guidelines determining practice. One of the concerns of nurses at the practice was their reliance on formalised sets of guidance. There was concern, for example, when a protocol was found to be in use when practice ought to have been guided by a National Patient Directive. There was also some anxiety about the difficulty of keeping locally produced protocols up-to-date and thus about the nature of evidence that underpinned practice. In addition there was a tension between nurses' freedom to exercise professional judgement and the implications of deviating from the protocol in response to previous experience or individual patient need. If a protocol exists and is not followed, this may be taken into account by a court considering poor practice, for example, in relation to the Bolam test (Tingle 1998). Nurses in the practice were aware of the need to document any deviation from the protocol, but the technology – the computer templates that recorded care – did not necessary allow them to do this in sufficient detail.

6.3 Concerns about accountability

Accountability raised considerable concerns, not least because of a lack of clarity in policy about what was meant when this term was used. Certain areas of practice appeared particularly problematic for practice nurses. Accountability was considered to be more of an issue or became heightened:

- in relation to certain patient groups, such as children;

- where nurses were working at the limits of their competence;

- where work in certain specialities such as family planning (especially in relation to issues such as emergency contraception) required quick decisions in which nurses might overstep the boundaries of their role in the interests of patients.

Documentation emerged as an important theme. It was seen both to protect practitioners from litigation (although it might lead to defensive practice) and to leave them open to litigation where it was inadequately carried out. This latter case might be due to pressure of work, but also because software design placed limits on certain kinds of documentation, particularly those associated with nursing practices. Staff felt that meeting patients' needs represented a huge responsibility – one that they could, to some extent, share with other members of the practice, but which also to some extent remained an individual charge for all clinicians. Policy, despite an emphasis on partnership working, and other directives such as those of the UKCC/NMC, tended to shape practice and lead to individualised ways of working.

7. Conclusion

This project was concerned to explore the relationship between the demands of clinical governance for both multidisciplinary working and clear lines of accountability, and what happens on the ground in clinical practice in one GP practice, using an ethnographic approach. It set out to:

✦ explore how accountability is understood across the health care team;

✦ identify who is involved in decision-making within the multidisciplinary team; and

✦ understand how the relationship between decision-making and accountability is viewed.

These areas were considered with a particular focus on practice nurses. This section of the report will briefly reiterate the study's findings, this time in relation to its original aims, before considering the limitations of the study and making recommendations for practice and further research.

7.1 Aims of the study

7.1.1 How is accountability understood across the health care team?

Although data was collected from a wider group, the study has focused predominantly on the views of nurses and doctors, particularly as the accountability of practice nurses has been one of the concerns driving the study, given their almost unique employment position.

The study found that considerable ambiguity attached to the concept of accountability that reflected the 'catch all' use of the term in current government policy. The term was often taken to mean responsibility, partly in the sense of deserving blame or credit. In many accounts, accountability was understood in terms of an imperative to act (or to refrain from acting) and a readiness to take the consequences of such action. In

addition it was used as a way of describing certain relationships, such as those between employers and employees or between clinicians and patients. There was therefore, little consistency in interpretation and the meaning of accountability. Instead, accountability seemed beyond precise definition. It was like an iceberg: menacing, only partially knowable, and its full shape could only be assumed. As one participant said 'The more you use the term "accountability", the more you wonder what it means'. Yet despite its abstract nature, accountability was pervasive and persuasive: it was continually alluded to across a range of discourses (policy, professional and everyday), and had come to motivate an array of practices. The vague yet omnipresent nature of 'accountability' suggests that it may represent a classificatory category, a web of meanings, partly ethical or moral in nature, partly personal or individual, but with a cultural resonance that lies largely beyond the reach of language. This approach to understanding accountability and its implications has not been fully explored but may be important for understanding the relationship between structural accountability (made concrete by the pattern of disclosures that might be owed) and attitudinal accountability, or accountability as an internalised disposition that may exist independent of organisational realities.

7.1.2 Who is involved in decision-making in the multidisciplinary team?

One assumption informing the study was that different members of the health care team might have different levels of input into multidisciplinary decisions, largely because of the historical relationships between the disciplines that they represented. It was anticipated, for example, that nurses in many instances would have a weaker voice than doctors. The study found instead, perhaps in line with other GP practices, that working in isolation was the rule for clinical work, rather than the exception. This is not to say that the practice was without clearly established multidisciplinary teams of varying membership, and for varying purposes. However, it did not appear that these teams functioned precisely in the manner suggested by clinical governance policy, in which groups of health care professionals are to hold each other accountable for

their performance. There was a review of practice that largely took place in practice or clinical governance meetings and included a range of staff. However, study participants appeared more preoccupied with everyday decisions about what action to take (that is, prospective rather than retrospective decisions). The physical isolation of practitioners during their work and the sequential nature of clinicians' involvement in patient care meant that such decisions were not made collectively by practitioners who were in the same place at the same time, but involved different practitioners at different points in a collective process. This sequential process appeared to provide individual practitioners with opportunities for input, irrespective of professional role.

Decisions concerning patient groups rather than individual patients (such as decisions about the development of protocols) or about the nature or development of practice services were made rather differently. These decisions had input, often carefully rehearsed, from across the spectrum of practice employees. However, some of these decisions had financial implications and could be shaped by the fact that the practice represented a small business owned by the partners.

7.1.3 The relationship between decision-making and accountability

Data from the vignette exercises in particular suggested that, hypothetically, some practitioners were seen as more accountable than others. Structural accountability was ascribed by some to those members of staff holding the most expertise (whether or not they were present at the time of decision-making). Lack of knowledge of a specific patient, in some instances, or lack of disciplinary knowledge (for example, where a nurse undertook a 'medical' task) was associated with a lesser degree of accountability. Data from interviews, observation and vignettes suggested that many staff thought structural accountability could be passed on from one practitioner to another, principally by providing a narrative or giving an account of decision-making. A number of staff seemed to suggest that partners carried ultimate accountability for what happened in the practice and, while the study was too small to demonstrate this, there was a suggestion that

understandings of the location of accountability varied across health care professions. This suggested variation reflects differences in approach within the statements of practitioners' regulatory bodies, such as the UKCC and GMC. The study was driven by concerns that nurses might be assumed to be legally or professionally accountable for decisions that they had not been fully involved in. However, the study suggests that, in this particular practice at least, individual clinician's lack of clarity about accountability for their own decision-making may be a more relevant concern. Finally, the study raised issues about the accountability of clinicians using aids to decision-making such as protocols. It suggests the need for research that looks at the relationship between patient need, clinicians' judgement and the knowledge on which more formalised guidance rests.

7.2 Limitations of the study

This was an ethnographic study of one general practice setting. The practice was relatively affluent, and characterised by good working relations amongst its staff, and motivation to introduce clinical governance. It was not representative of many other GP practices. An ethnographic approach allows in-depth study of the everyday life of a practice, but the study's findings cannot be taken to necessarily reflect what happens in other practices. Instead they offer food for thought.

It proved very difficult and time consuming to find a practice willing to host the study. This was largely because of enormous changes taking place within primary care at the time, such as a shift from PCG to PCT status, and partly perhaps because of the potentially sensitive nature and timing of the study. Difficulty in finding a research site meant that the time available for fieldwork was curtailed. As a result there is less data than anticipated concerning the process of decision-making over time. In addition, requirements of the local research ethics committee, designed to protect patients from being pressurised to consent to observation, meant that we were able to carry out less direct observation of care and clinical decision-making than originally planned.

Finally, accountability, given its many meanings and the way in which one meaning may shade into another, is extraordinarily difficult to research. With hindsight it seems that context is important in helping to establish the meaning intended either by the study participant or

the researcher. To some extent, our questioning may have inadvertently shaped some of the responses we received by not giving the context sufficient attention. For example, while the vignettes were helpful in drawing out the range of different understandings of accountability, the way that the vignettes were presented – namely by asking: 'In the following scenario, who do you see as being accountable?' – may have unintentionally suggested that we were interested in accountability in terms of blame. In any future study of accountability involving this method, vignettes would need to be introduced in a more tangential way – for example by asking how certain scenarios might be reflected on by the different clinicians involved during clinical supervision. Alternatively, it might be more productive to ask practitioners to describe a complex clinical situation involving different kinds of health care professionals that they had been involved in (that is, to give an account) and go on to discuss the issues that this situation raised.

7.3 Recommendations

Recommendation one: ambiguity in the literature and the clinical area about the nature and extent of the accountability of different professional groups jointly involved in decision-making suggests the need for a joint statement of clarification from the main regulatory bodies.

Recommendation two: findings from this ethnographic study suggest that multidisciplinary decision-making may be limited in the primary care context because of lack of opportunity for colleagues to meet collectively and because of the constraints placed on collective decision-making within general practices as small businesses. A broader study based on survey and multiple case studies is therefore proposed to further explore the nature, extent and implications of multidisciplinary decision-making in primary care.

Recommendation three: the study identifies the importance of protocols for practice nurses who are working at the margins of existing nursing roles, but also highlights concerns about the status of the knowledge on which these protocols are based, and about the relationship between these tools and practitioners' clinical judgement. This suggests the need of further research which explores the way in which GP practice protocols are developed and maintained, and

investigates the relationship between protocols, clinical judgement and accountability.

Recommendation four: the lack of practitioner clarity about professional and legal accountability in a changing health service suggests the need for continuing professional development in this area. The study indicates that it would be useful to develop resources such as workshops or videos that use different clinical decision-making scenarios to explore and improve practitioners' understanding of their accountability in different contexts.

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Appendix 1

Practice nurses' tasks as identified by Mackereth (1995)

PRACTICAL TASKS	SCREENING ACTIVITIES	HEALTH PROMOTION/ DISEASE PREVENTION
Maintain stock of dressings	ECG tracing	Advise on smoking
Take blood samples	Eye exam and treatment	Advise on nutrition
Ear syringing	Ear exam and treatment	Advise on family planning
First aid	Audiometry	Assist/run well woman clinic
Dressings	Peak flow rates	Assist/run well man clinic
Assist with minor surgery	Assist or run asthma clinics	Advise on incontinence
Take blood pressure	Urinalysis	Advise on alcohol use
Suturing	Assist or run diabetes clinics	Advise on drug use
	Perform/teach breast exam	Immunisations
	Cervical smears	Advise on accident prevention
	Teach testicular self-exam	Advise on stress and relaxation
	Detect family violence	Lifestyle counselling
	Assist in hypertension clinic	Travel advice
	Counsel patients	
	Child health surveillance	
	Elderly person health surveillance	

Appendix 2

Vignette 1

Practice nurse Carol Smith works in a medium-sized general practice setting in a semi-rural location run by three GPs and offering a broad range of services. One of the general practitioners has an interest in cardiology and has been in the process of setting up an audit of patients with known cardiac disease and those with significant risk factors. The GP and Carol Smith have recently set up a nurse-led service/clinic to offer prevention advice to those patients at risk of heart disease.

During one of these clinics Mr Jones attends for his appointment with Carol Smith. He complains of general symptoms of indigestion which 'come and go'. He has no history of heart disease but has diabetes and recently gave up smoking. On further questioning Carol Smith decides to ask for advice from one of the GPs. The GP who has a cardiology interest is not present that day. The GP she consults advises her to take an electrocardiogram (ECG) to be on the safe side and he would look at it later. Carol Smith carries out the ECG. She has not yet received specific training in reading ECGs. Given that Mr Jones is asymptomatic and the GP is busy and did not feel there was any real cause for concern, she advises Mr Jones to go home and come back if the symptoms return. On the way home Mr Jones collapses and is admitted to hospital with a myocardial infarction. The family contacts the practice in a distressed state asking why he was not seen by a GP.

Vignette 2

Jane Brown is a practice nurse based full time in a city practice run by a single GP, Dr Best. The practice serves a population in a deprived area of the city with high unemployment and a high proportion of patients with mental health problems. Jane Brown has been at the practice for only a few weeks and has asked the GP if she can attend a mental health course, run at the local university. Dr Best agrees in principle, but states that the practice is very busy and she cannot agree to study time for the time being.

During morning clinic, Mrs Wallis attends for her injection for treatment of schizophrenia. Jane Brown notes from the records that this patient is well known to the practice and has been attending recently for counselling for depression. Dr Best has been seeing Mrs Wallis every week, however Mrs Wallis missed last week's appointment and has not made another. Jane Brown attempts to ascertain the mental well-being of the patient but, given the limited time available and her inexperience, she is unable to assess the patient fully and makes a note to talk to the GP about this patient. She does feel instinctively that Mrs Wallis is still very depressed but feels it would be inappropriate to keep her in the surgery based on instinct alone. At the end of morning surgery she talked to Dr Best about Mrs Wallis. She has known the patient for years and despite one previous attempt by Mrs Wallis to take her life, she was not concerned during recent counselling sessions that this patient was at risk. Jane Brown found it difficult to explain her instincts and due to her new employment status and inexperience she did not feel she was in any position to question the GP's view. Later that week, Dr Best informed her that the patient had attempted suicide.

Appendix 3

Information sheet and consent forms

Royal College of Nursing Institute
Radcliffe Infirmary
Woodstock Road
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OX2 6HE

Staff Information sheet

**An ethnographic study of nursing accountability
in the context of primary care, clinical
governance and multi-disciplinary decision-making.**

Lucy Moore
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Applied and Qualitative Research Ethics Committee number: A00 …

Introduction:
As a member of the research team at the RCN Institute, I would like to invite you to take part in the above study, supervised by Dr Jan Savage.

Before you decide if you would like to take part, I would like to explain why the research is being carried out and what it would involve. We would be grateful if you could read the following information and discuss it with your colleagues with a view to deciding if you wish your practice to be involved in the study. If anything is not clear, or if you would like more information, please feel free to ask me (Lucy Moore – contact details above). Alternatively, if you have concerns about your involvement in the study that you would like to discuss with an impartial person, please contact …… at ……. Please take the time you need to decide whether or not you wish to take part.

The study:
The research project you have been asked to join is concerned with clinical governance and the relationship between the multidisciplinary decision-making that this promotes and individual accountability. The study is particularly concerned with the perceived accountability of practice nurses, given the varied nature of their employment. Research in this area has previously used surveys and questionnaires. In contrast, this study aims to achieve an in-depth understanding of clinical governance and accountability from the staff's own perspective and within the context of their working environment.

M.Phil. component: Part of the above study would also include a more in-depth exploration of nurses' involvement in clinical governance within primary care. It aims to explore whether, or how, primary care nurses participate in clinical governance and what factors may inhibit or promote participation. The researcher would submit this part of the study for a M.Phil. degree.

Who would be involved?

Ideally we would like all members of a practice to agree to be involved in the participant observation arm of the study, and the informal discussions this may include. Formal interviews would be with clinical staff, and in the case of the clinical governance component, would be only with primary care nurses.

What would I have to do if I chose to take part?

If you agree to take part, this would initially mean allowing the researcher to observe you in everyday work activities such as formal and informal meetings. You would be asked to sign a consent form at the beginning of the study, but this would not mean that you had to participate each day that you are on duty. The researcher would check with you that you wished to be included at the beginning of each day of observation. The aim is to understand more about the way that decisions are made within the multidisciplinary team, and how people work in relation to issues of clinical governance and accountability.

A further part of the study would include interviews with clinical staff, focusing on perceptions of decision-making and accountability. Interviews would be tape-recorded, but only with the permission of individuals. The interviews would include the use of vignettes to allow the discussion of hypothetical situations that are relevant to, but distanced from, individuals' own practice. These interviews would be carried out at work, in a quiet private room, at a convenient time for staff and would last approximately 45–60 minutes.

If you are a primary care nurse, you would be asked to consider taking part in a second interview, looking specifically at your involvement within clinical governance.

The final part of the study involves analysing documents such as protocols and standards, and other relevant written work (excluding patient records) that may throw light on decision-making processes and clinical governance.

All responses would be confidential and complete anonymity would be maintained in the publication of results.

Do I have to take part?

It is up to you to decide whether or not to take part in the study. If you would prefer not to take part you do not have to give a reason. If you decide to participate, you are still free to withdraw from the study at any time, without having to provide an explanation and you may ask for information you have provided to be omitted from our records. We will provide you with the contact details of an independent person with whom you can confidentially discuss any concerns that you may have about the research.

If you decide to take part you would be asked :

a)   to give written consent for participant observation (the research will also check with you for verbal consent before each occasion of participant observation);

b)   to give written consent for any recorded interview you grant the researcher.

You will be given a copy of this information sheet and signed consent forms to keep.

What do I do now?

We would be grateful if you would consider this invitation with your colleagues. If you are interested in taking this further, I will be pleased to visit the practice and answer any questions, before a confidential ballot to see if there is collective agreement on the involvement of your practice. In the meantime, if you would like any questions answered to help you make an initial decision, please do not hesitate to contact me.

Thank you for considering taking part in this research.

Consent form for interviews

Applied and Qualitative Research Ethics Committee number:

Title of Project: An ethnographic study of nursing accountability in the context of primary care, clinical governance and multidisciplinary decision-making.

Name of Researcher: Lucy Moore

Please initial box

1. I confirm that I have read and understand the information sheet dated .... (version ....)
   for the above study and have had the opportunity to ask questions. ❏

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving
   any reason, without my employment or legal rights being affected. ❏

3. I agree that any words I may say during the interview can be used, anonymously, in the presentation of the
   research. ❏

4. I agree for the interview to be tape-recorded but that I can stop the recording at any time and ask for the
   tape to be destroyed. ❏

5. I agree to take part in the above study. ❏

_____ _____ _____

Name of participant   Date   Signature

_____ _____ _____

Name of person taking consent   Date   Signature
(if different from researcher)

_____ _____ _____

Researcher   Date   Signature

Consent form for participant observation

Applied and Qualitative Research Ethics Committee number:

Title of Project: An ethnographic study of nursing accountability in the context of primary care, clinical governance and multi-disciplinary decision-making.

Name of Researcher: Lucy Moore

Please initial box

1. I confirm that I have read and understand the information sheet dated .... (version ....)
   for the above study and have had the opportunity to ask questions ❏

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving
   any reason, without my employment or legal rights being affected. ❏

3. I agree that any words I may say during participation observation can be used, anonymously, in the
   presentation of the research. ❏

4. I agree that the researcher can shadow me during my everyday activities at work, subject to my continuing
   agreement. ❏

5. I agree to take part in the above study. ❏

_____   _____   _____
Name of participant   Date   Signature

_____   _____   _____
Name of person taking consent   Date   Signature
(if different from researcher)

_____   _____   _____
Researcher   Date   Signature

Appendix 4

Association of Social Anthropologists of the Commonwealth

Ethical guidelines for good practice (ASA 1999)

'Relations with and responsibilities towards research participants'

1. **Protecting research participants and honouring trust:** The paramount obligation is to the research participants and when there is a conflict of interests the rights of those studied should come first

2. **Anticipating harm:** Researchers should be sensitive to the possible consequences of their work and should endeavour to guard against predictably harmful effects

3. **Avoiding undue intrusion:** Researchers should be aware and sensitive to the fact that the methods can intrude into private and personal domains.

4. **Communication information and obtaining informed consent:** The principle of informed consent is, essentially, an expression of belief in the need for truthful and respectful exchanges between social researchers and the people whom they study. Consent in fieldwork is a process, not a one-off event, and may require renegotiations over time.

5. **Rights to confidentiality and anonymity:** Research participants should have the right to remain anonymous and to have their rights to privacy and confidentiality respected.

6. **Fair return for assistance:** There should be no exploitation of research participants; fair return should be made for their help and services.

7. **Participant's rights in data and publications:** It should be recognised that research participants have moral, and sometimes contractual and/or legal, interests and rights in data and publications.

8. **Participant's involvement in research:** As far as possible anthropologists should try and involve the people being studied in the planning and execution of research projects.

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