Rules in the Clinical Setting: Pros and Cons

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No one should deny the importance of providing patients with the right care at the right time. The author describes how this goal was pursued in his own district general hospital [1]. An important part of the plan was to develop policies for drug prescribing, resuscitation, nutrition, and so on, and enforce them within the hospital. For example, the policy for admission to intensive care for myocardial infarction consisted of five criteria, including ‘Patients presenting within four hours of onset of pain’, and ‘Patients with significant ventricular dysrrhythmia (multi-focal or frequent ventricular ectopic beats or ventricular tachycardia)’. The policies were published, updated when necessary and circulated to relevant staff (nurses, doctors, pharmacists, nutritionists, laboratory workers). Hospital-wide, the result appears to have been beneficial: low mortality from life-threatening asthma, increased kidney transplant donations and significant financial savings. However, we can still wonder what role the rules played in this success. Could even better results have been achieved without the rigid rules? To what extent was success due to the expertise of the staff? Was there a downside to the policies? I outline here some of the advantages and dangers of using hard-and-fast rules in a clinical setting.

One of the obvious benefits of rules is that they stave off anarchy. Of course, the rules must be such that they do not actually promote anarchy. Confusion is likely to result, in varying degrees, if rules are inconsistent or vague. In a hospital setting, for example, rules such as ‘Ask someone else’ or ‘Do first things first’ will produce chaos rather than order if they are actually used as guides to action. Of course, the greater the expertise of a clinician, the less likely it is that such rules will produce chaos, but this is because the clinician is relying on his or her expertise rather than the rules. Furthermore, even the best rules will not have beneficial effects if they are not followed, at least most of the time. This being said, one of the attractions of good (consistent, unambiguous...) rules, conscientiously followed, is that they help to create an ordered environment.

It would be easy to reject outright the use of rules in the clinical setting, but we must not be too hasty. We all constantly govern our own behaviour in accordance with rules. Often we would be hard pressed to articulate the rules we are following. But in a context where our behaviour can have serious consequences for ourselves and others, such as in the clinical setting, there may be great value in attempting to make policies and procedures explicit, for in this way they become open to critical examination and thus to improvement. Similarly, there is value in making the rationales underlying the policies and procedures explicit: again, policies and procedures will improve over time if reasons must be articulated.

One way in which rules help to create order is by providing for predictability of response. Each doctor and nurse who is familiar with the rules can anticipate what his or her colleagues will do—or can better anticipate it—on the assumption that everyone is familiar with the rules, and committed to following them (most of the time). A concomitant of this predictability
is the increased feeling of security it can engender in the medical, nursing, and other staff. Of course, this is only true to within the limits of the rules. Again, the more equivocal the rules the greater the potential for variation in response, and thus the less security they are likely to engender. But this being said, rules can play an important role in coordinating behaviour.

The author mentions that his hospital was understaffed. Hence, the method for selecting patients for admission to intensive care was by reference to explicit criteria. More accurately, each different disease or condition (myocardial infarction, asthma...) had a different set of criteria. In situations where an experienced clinician is not available, the use of such rules may be the next best option. The rules can be justified on the ground that they stand proxy for the absent clinician. (Of course, there is a serious question here about just when a clinician is 'unavailable'.) This is not to say that rules can or should replace human judgement—indeed, they are merely the embodiment of human judgement—just that they may be the next best thing when a person with the relevant expertise is not available.

Turning to the dangers, and beginning with the most obvious, rules can be incorrect and may not be recognised as such. People can come to rely on rules, even bad rules, especially if they have been published in the form of enforceable policies. Rules that have been actually written down may assume an authority that usurps an individual's better judgement. One of the potential benefits of rules, of course, is that they do in fact supersede individual judgement—or are intended to. But this is only a benefit when an individual's judgement is inferior to the judgement encapsulated in the rules. But what happens when the rules are wrong, or inapplicable in a particular instance? Rules tend to be conservative—they reinforce accepted practice—but when that practice needs changing they can be a hinderance and a danger.

Some areas of clinical practice may simply not lend themselves to governance by rules. For example, the author says that his hospital had problems securing organ donations. One of the possible reasons cited was that 'staff are unwilling or unable to obtain permission from the next of kin'. But it may be extremely difficult to put in place rules for obtaining permission from next of kin. It involves sensitivity, and the ability to empathise with others—particularly with those who may be grieving or in shock. Indeed, such sensitivity is crucial in many areas of clinical practice. These intangible human skills are virtually impossible to encapsulate in rules, a fact that has been known for years to those responsible for training doctors and nurses. So we must be cautious not to extend rules into domains where they do not belong.

Psychologists distinguish between propositional knowledge and procedural knowledge. For example, a person may have a great deal of propositional knowledge about riding a bicycle (they understand what tyre traction is, they know the difference between velocity and acceleration, and so on), and yet not know how to do it. They lack the skill or ability to ride a bicycle, despite their theoretical knowledge. Similarly, a doctor or nurse may have a thorough knowledge of certain rules as propositions—indeed, know them back-to-front in this sense—but lack the skills to put them into use. This is potentially a serious problem, for if a member of the hospital staff 'knows' the rules well in the propositional sense, they may be deceived into thinking that they 'know' the rules well in the procedural sense also, when in fact they do not. In this way, rules may lead to over-confidence or a false sense of security.

The use of rules may also fail to respect the moral autonomy of hospital staff, and compromise personal integrity. This, of course, is one of the big drawbacks of rules. The author notes that 'there are many instances of irreversible disease in which cardiac arrest is a merciful release from suffering and that attempts at resuscitation are unethical'. Resuscitation is unethical in the case of 'incurable disseminated cancer or when chronic disease—renal, cardiac or pulmonary—has caused intolerable disability'. But this involves imposing a moral code on hospital staff. Moreover, it is not clear whether staff were obliged to follow this policy despite the wishes of the patient or the patient's family. Were the rules endorsing voluntary, non-voluntary or involuntary euthanasia? We must be careful that moral rules are not masquerading...