The Intuitive-Humanist Decision Making Model, Ethics, and Nursing Philosophy

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**Introduction**

It is my opinion that the nursing profession manifests the care felt towards others. The art and practice of nursing represents one way to provide compassion and nurturing to patients who are in the most need. When whittled down, this compassion in nursing intensifies into a passion for one population and environment such as adult oncology or pediatric cardiology. In my case, the field of neonatology has always been a source of wonder and admiration. Within this discipline, decisions made today will impact these tiny ones for their lifetime. In various other populations actions may impact ten, twenty, or even fifty years, but only in neonatology can the results of our actions determine how a person will grow from infancy and develop through the coming years. While a long healthy life is always the ambition, it is also true that some neonatal lives are fleeting. In these cases, neonatal nursing provides comfort, support, and facilitates bonding and memory making for families. The impact of a new life whether sustained or in brevity is immeasurable and the effect of the work done in the field of neonatology is equally magnanimous. Advanced practice nursing in the neonatal population adds another facet to the multi dimensional environment that already exists within the intensive care nursery. Advanced practice in this setting offers endless possibilities for obtaining knowledge that, while age specific, spans the breadth of organ systems, encompass congenital defects of all kinds, and includes those who enter the world much too early. In my nursing career I hope to provide care to the best of my ability, to any infant under my care, with respect to family hopes and wishes, and to achieve the best possible outcome for every baby in their specific situation. This is my philosophy.

**Theoretical Framework**

 Intuition has a variety of definitions and explanations proposed by as many authors. Gerrity suggests that intuition is a perception of possibilities, meanings, and relationships by way of insight (as cited in Banning, 2008). Schrader and Fischer describe intuition as the immediate knowing of something without conscious use of reason (as cited in Banning, 2008), and according to Rew, intuition is a component of complex judgment, and the act of deciding what to do in a difficult situation (as cited in Banning, 2008). Perhaps most famously, Benner and Tanner (1987) defined intuition as “understanding without rationale” (p. 23). Intuition plays a large part in the intuitive-humanist model. The intuitive-humanist model is one of two theoretical frameworks in clinical decision making (Banning, 2008), the other being information processing theory. According to Banning (2008), “the focus of this model is intuition and the relationship between nursing experience, the knowledge gained from it, and how it enriches the clinical decision making process as the nurse progresses along the professional trajectory” (p. 189).

 The intuition-humanist framework has evolved over decades of nursing practice and research into the way nurses think, react, and behave. As far back as 1970, nursing theorists were describing the role of intuition in practice. Wiedenbach explained that intuition is what accounted for nursing wisdom, and a few years later Carper included ‘personal knowledge’ as one of her modes of nursing knowledge (as cited in Green, 2012). Over the next decade, works from Benner and Dreyfus emerged and have since caused paradigm shifts in thinking as it relates to intuition. In the now renowned 1987 work, Patricia Benner and Christine Tanner define intuition and describe its role in nursing practice. According to Blum (2010), the intuitive-humanist model is “unlike the traditional linear thinking associated with the nursing process, intuition recognizes holistic modes of thinking” (p. 205). This type of model is less scientific and more of a natural progression in thinking. Using the six key aspects of intuitive judgment proposed by Dreyfus and Dreyfus in addition to points from the earlier work *From Novice to Expert*, Benner and Tanner developed the intuitive-humanist model. The components borrowed from the work of Dreyfus and Dreyfus are pattern recognition, similarity recognition, commonsense understanding, skilled know-how, sense of salience, and deliberative rationality. Pattern recognition is “a perceptual ability to recognize relationships without pre-specifying the components of the situation” (Benner & Tanner, 1987, p. 24). In the clinical setting, pattern recognition is the ability to recognize a set of factors that occur in a certain situation or presenting illness. Similarity recognition is the human capacity to “recognize ‘fuzzy’ resemblances despite marked differences in the objective features of past and current situations” (Benner & Tanner, 1987, p. 24). Similarity recognition is also effective in noticing dissimilarities among circumstances. The ability to recognize the same or different qualities or aspects in a situation “makes problem identification possible in highly ambiguous circumstances (Benner & Tanner, 1987, p. 24). Commonsense understanding is an appreciation of culture and language which makes it possible to comprehend diverse situations (Blum, 2012). Two kinds of knowledge have been proposed by Polanyi and Kuhn, ‘knowing how’ and ‘knowing that’ (as cited in Blum, 2012). Skilled know how refers to the take-over of skill when something is no longer a new or uncomfortable task and that task is completed naturally. A sense of salience describes events and observations that stand to be more important or less important clinically (Blum, 2012). Essentially a sense of salience is the ability to separate nuances from the important cues. Lastly, deliberative rationality “is a way to clarify one’s current perspective by considering how one’s interpretation of a situation would change if one’s perspective were changed” (Benner & Tanner, 1987, p. 28). The intuitive-humanist model is over laid with the previous works of both Benner and Dreyfus. The Model of Skill Acquisition by Dreyfus and the later modification for nursing practice in *From Novice to Expert* by Benner both discuss the movement through five stages of proficiency. The progression from novice, through advanced beginner and competence, to proficiency and finally into expertise is also present in the intuitive-humanist model. Benner (as cited by Blum, 2010) outlines the relationship between the expert nurse and intuition by saying “intuitive knowing is inherent to the expert nurse” (p. 305).

**Ethical Concepts**

The ethical concepts that I utilize in practice mirror those outlined by the American Nurses Association. The concepts of autonomy, beneficence, nonmaleficence, and justice all guide decisions made and clinical actions.

**Autonomy**

Foremost, the ANA will define autonomy as the respect of another’s right to decide their own course of action while promoting independent decision making (ANA, 2011). Translating autonomy into the neonatal population does pose concerns since a newborn cannot speak for itself. Powell et al. (2012) discuss the principle of autonomy in this population saying “because infants are unable to act autonomously, their parents must become surrogates for medical decision making” (p. 28). These authors further discuss the often emergence of birth in the neonatal intensive care population and how this may negatively affect parents autonomy. When the birth of an infant happens early, it is difficult for parents to comprehend everything that is occurring around them. “Without being fully informed, parents may not completely comprehend the outcome of an extremely premature birth” (p. 28).

**Beneficence & Nonmaleficence**

The next principle, beneficence, is defined by the ANA as compassion, as taking positive action to help others, and is the basis of patient advocacy (ANA, 2011). Once again, the neonatal population presents unique and sometimes difficult challenges with respect to ethical principles. Beneficence in the neonatal population can be applied either to the practitioner and care team, or to the parent (Powell, Dedrick, Salvo, & Huff, 2012). As providers, we must be beneficent in the care we provide to ensure it is in the best interest of the patient. The parent’s role is even more complicated and parents must ensure the best decisions are being made for the infant despite the time of crisis. “It is an emotional time, and parents may only be able to focus on the fact that they are making a decision that will potentially lead to their infant’s death” (Powell, Dedrickm Salvo, & Huff, 2012, p. 28). Emotions, morals, beliefs, cultural beliefs and provider standpoints can all influence beneficence in the neonatal population. It is of the upmost importance to be cognizant of our infants needs regardless of outcome. To do no harm is the core of both medical and nursing ethics (AMA, 2011). To contrast beneficence, nonmaleficence is not causing harm. In more modern terms, nonmaleficence refers to doing no harm with the advances in technology and experimental treatments (AMA, 2011). In neonates, the provider must weigh the benefits of providing care while attempting to minimize harm (Powell, Dedrickm Salvo, & Huff, 2012).

**Justice**

 Justice is the final principle discussed. “This principle refers to an equal and fair distribution of resources, based on analysis of benefits and burdens of decision. Justice implies that all citizens have an equal right to the goods distributed, regardless of what they have contributed or who they are” (ANA, 2011, 2). With regard to the neonatal population, justice requires providers to make decisions based on the best interest of the infant. These decisions must be consistent regardless of race, ethnicity, or the ability of a family to cover the medical cost (Powell, Dedrickm Salvo, & Huff, 2012). In addition, Skupski et al. (2010) describe procedural justice as taking all individuals involved into account. Skupski et al. (2010) also discuss substantive justice which requires that exploitation be prevented, exploitation occurring when a small percentage of a population receives a benefit such as survival and a large portion of the population experiences clinical harm, mortality, or serious disability. Another interesting aspect of justice, however, is distributive justice where the implications of caring for an infant are taken into consideration. The decision to resuscitate an infant with a condition not compatible with life may have a lasting impact on the infant, family and society. The revenue and resources needed to resuscitate, manage, and care for some infants may devastate parents and become a burden to the healthcare system as a whole. For some providers, distributive justice may be a deciding factor in major healthcare decisions for their patients.

**Relationship between philosophy, ethics, and the Intuitive-Humanist Framework**

 The history of ethics in neonatal intensive care extends back to the 1970s when neonatology was just beginning to gain momentum as a subspecialty. It was during this time that a landmark article was printed in the New England Journal of Medicine and revealed physicians who sometimes withheld lifesaving technologies from patients with poor prognosis (Mercurio, 2011). The dynamic created between the intuitive-humanistic model, ethical principles, and nursing philosophy is intricate and is often satisfactory. The majority of conflicts that could be of concern arise in situations where it is difficult to determine the right and best thing to do for a neonate. Each of the four ethical principles discussed above has the ability to cause a great deal of discourse in the plan of care for an infant in crisis. Each of these principles relates closely to the next creating a unique, complex, and confusing ethical predicament for some patients within this population. The use of the intuitive-humanist model is primarily unvarying with each concept and comes into play when recognizing and similarities and patterns that have previously caused ethical dilemmas.

**Autonomy**

As discussed above, the notion of the patient’s right to choose the path of their care becomes the burden of the parents in the intensive care nursery. “Newborns cannot exercise their right to self-determination or autonomy, and therefore their parents who are their natural surrogates are the ones who will usually make decisions with the child’s best interest in mind” (Douglas & Dahnke, 2012, p. 35). While the hope and expectation is that decisions are being made in the infant’s best interest, decisions are often based on emotion, confusion, and lack of education. To have an infant needing the support of the intensive care nursery puts parents in a position of submission and uncertainty regarding their baby. “This conviction is compounded the first time they enter the unfamiliar, somewhat threatening, environment of the unit, filled with hi-tech equipment and busy medical and nursing staff. This generates a profound disorientation in the parents” (Orzalesi & Aite, 2011, p. 135). Confusion, combined with a probable lack of education, can lead to incongruence between what should be decided for their infant and what is being decided for their infant. Breakdowns in communication have been cited as being common cause of parents making decisions that ultimately harm their children (Orzalesi & Aite, 2011). In order to combat this, practitioners have a responsibility to parents to properly educate them prior to, during, and after the birth of their infant. Open lines of communication should be established early and parents should be informed not only of the probability of their infant surviving, but also about the related morbidities, and long term care neurological deficits that can be expected should the child survive. With proper education and knowledge regarding their infant’s prognosis, perceived challenges, and possible outcomes, parents are better prepared to act on their child’s behalf.

The principle of autonomy should also be discussed as it relates to the care provider. In difficult cases, choices and decisions made by parents may be disregarded, and therefore challenged, by the practitioner. Historically, medical decisions regarding viability or quality of life at birth were exclusively made by the medical team and until 1984, there was little debate or argument regarding the resuscitation practices of practitioners. “In 1984, the federal Child Abuse Amendment (CAA) became strongly protective of the rights and interests of the disabled and left little room for nontreatment [*sic*] decisions based on quality of life or the interests of parents” (Eden & Callister, 2010, p. 30). In light of the Child Abuse Amendment, physicians are resuscitating medically fragile infants regardless of parent’s decisions to withhold care. Given that the Child Abuse Amendment requires neonatologists to treat infants regardless of physical or mental disability, providers are protecting themselves and resuscitating at birth leaving decisions to later withdraw care in the hands of parents (Eden & Callister, 2010).

Combined, challenges to autonomy result from parents who are faced with the immense and challenging responsibility to make appropriate decisions in addition to health care providers who act in their own legal interest before acting in the best interest of the patient. Therefore, while parental authority is strong in autonomy and decision making, it is not absolute and this fact may contribute to or deflect from ethical dilemmas.

 The benefits and challenges of autonomy are also present in personal practice. My philosophy composed at the commencement of this document speaks to respecting families’ wants and wishes. The concept of autonomy in the neonatal intensive care unit is, essentially, to provide parents with the resources and education necessary to make appropriate care decisions for their infants. The push toward family centered care has brought to light the previous deficiency in parental involvement. Presence in rounds, listening to nurse report, and having multidisciplinary family care conferences are all ways to increase parental involvement, communication, and autonomy.

**Beneficence and Nonmaleficence**

The principles of beneficence and nonmaleficence are very closely related in the field of nursing and the same holds true within the neonatal population. As described above, beneficence is the act of doing good acts for others while nonmaleficence is doing no harm towards others. These ethical concepts can be seen most prominently in the neonatal population in situations regarding infants who are extremely preterm, those who have congenital malformations, or those with genetic processes that are not compatible with life. These neonates, born between 22 and 24 6/7 weeks, are now deemed periviable because “they are so immature that a great percentage of them won’t survive and those that do will often have major morbidity” (Douglas & Dahnke, 2012, p. 34). While current technologies have given healthcare providers the means and ability to save lives formerly thought to be hopeless, it has more recently come to light that even though these technologies exist, the life we are saving often have little to no quality. The realization and acceptance of this juxtaposition is what leads to ethical dilemmas present in the neonatal intensive care unit. Douglas and Dahnke (2012) discuss the intricate relationship between beneficence and nonmaleficence by stating “if an infant’s prognosis is favorable, the ethical principle of beneficence guides the professional to assist the parents to make treatment decisions, and to help them care for and bond with the infant” (p. 35) and also that “if the prognosis is grim or virtually hopeless, in terms of meaningful survival, nonmaleficence dictates that comfort care of the infant, and support during parental grieving is most important” (p. 35). The act of giving or withholding care is not mutually exclusive to the principle of beneficence or nonmaleficence. In order to provide good care for an infant, it may be necessary to do nothing at all.

With regard to personal experience, I have seen both principles in practice at the bedside. The thought of having the ability to provide the opportunity at life or to withhold care is awe inspiring. A responsibility of such magnitude can be nothing but humbling and must be approached with great caution. My personal thoughts and philosophies regarding nursing meld nicely with these two principles in particular. ‘To provide the best care possible’, which translates into beneficence. An interpretation of ‘the best possible outcome for every baby’ yields the definition of nonmaleficence. Both of these concepts are important in practice and while ethical conflicts do arise I am most at ease vacillating between beneficence and nonmaleficence.

**Justice**

Justice, as discussed above, refers to equal access to care and resources. For infants, justice translates into access into the neonatal intensive care unit (Barnum, 2009). Ethically justice has the potential to become problematic when situations regarding prolonged, costly treatments contribute to the patient’s medical status. One of the most researched and documented aspect of this kind of injustice is futile care. According to Chiswick (2008), futile care can be described as those actions and intervention which have no hope to achieve the desired outcome. Chiswick (2008) maintains that “a point of futility is ordinarily reached when it is felt that a patient has ‘entered the process of dying’” (p. 13). To define the process of dying is difficult in itself as the dying process could be interpreted differently by different providers. Multiple organ failure should be seen as a reasonable landmark by which to measure the dying process Cheswick (2008). The concept of futility is only confounded that much more in the neonatal population where life threatening events occur suddenly and sometimes with little indication of trouble. In addition to the impact futility has on patients, this concept has effects that reach further into the healthcare team. “Health-care professionals experience moral distress and frustration when, due to demands of families, they provide infants with treatment they feel is inappropriate. This action results in needless suffering in infants and the use of scarce and costly health-care resources” (Eden & Callister, 2010, p. 30). As highlighted by Eden and Callister (2010), with regard to the principle of justice, futility translates into an increase in spending and depletion of resources. Douglas and Dahnke probe further and ask “should society pay for the extended treatment of these marginally viable newborns, especially when they may have little to contribute in the future, or do we owe them the right to have a chance at some sort of life?” (p. 36). Procedures like an arterial stick for laboratory work, an echocardiogram for duct evaluation, or serial chest radiographs could all be deemed futile if the neonate has no hope at achieving a positive outcome. An extensive list of procedures, laboratory tests, medications, equipment use can result and with it an equally as extensive bill.

Futility and justice personally imply having the measures in place to ensure everyone is given equal treatment. Justice translates into practice for me through protocols, policies, and other process designed to standardize care. While futility is an occurrence I have witnessed, it remains a difficult topic to navigate. There is a fine line between allowing a family to have hope for recovery and leading them to acknowledge when care has become futile. Perceptions that the healthcare team has given up on the infant may occur and this further emphasizes the need for good communication between the provider and the family.

The Intuitive-Humanist framework is relevant in each of the ethical conflicts and principles discussed above. While every patient brings with them a unique composition of culture, family, and spirituality, the Intuitive-Humanist framework allows providers to recognize those patients who may be at risk for ethical dilemmas and intervene accordingly. As defined previously, the Intuitive-Humanist model is based on the relationship between nursing experience and knowledge gained through experiences. Ethically, the framework acts to identify patterns, see similarities, and understand their implications moving forward. With regard to autonomy specifically, the Intuitive-Humanist model allows the practitioner to draw from past experience to supply parents with honest dialog regarding prognoses and anticipated complications. Beneficence and nonmaleficence are aided through this framework due to the treatments previously attempted in infants. This not only allows for growth within the field of neonatology, but provides a basis from which decisions regarding care can be made. Similarly, the Intuitive-Humanist model lends itself to the principle of justice through skilled know-how, a sense of salience, and deliberative know-how. These concepts are integral to the framework and are easily incorporated into ethical considerations.

**Implications for Practice**

 To incorporate both the Intuitive-Humanist model and the aforementioned ethical principles, the practitioner must first do a self-assessment. Knowing your ethical opinions allows for the incorporation or exclusion of feelings in various situations. Knowing the importance of ethics and their intimate relationship with the neonatal intensive care environment further prepares the practitioner for successful integration and practice. Doing a self-assessment also allows the practitioner to ascertain their level of proficiency with the neonatal population. From here, the concepts presented within the Intuitive-Humanist model can be laid into place.

 Ethics within the neonatal population are a mainstay. Differences in ethical beliefs between the provider, family, and health care team have the potential to cause negative outcomes for the patient. To combat this in practice, it is necessary to listen to and understand a parent’s concerns regarding their baby. Putting aside personal feelings and beliefs may be necessary to guide parents toward the most appropriate decisions. Having respect for the autonomy of the parents is crucial. In addition, it is necessary to ensure that decisions made are in fact beneficial to the infant and also to remember that not providing care is sometimes the best option. Using beneficence in conjunction with nonmaleficence allows for the best care to be provided. In order to guarantee every patient has an equal opportunity is also the obligation of the practitioner; however, the provider must also be cognizant of futile efforts and wasteful uses of resources. Acknowledging and understanding these ethical principles allows for uniformity in practice with lesser occurrences of moral distress.

 As the practitioner gains experience, reliance on guidelines will diminish and confidence in intuition will increase. Each of the six concepts outlined in the work of Benner and Tanner will develop, individualized to the practitioner. Matriculating through the levels from novice to expert will not only strengthen practice but will also allow for personal growth. Using the Intuitive-Humanist model in the neonatal intensive care unit is both logical and practical; this model accounts for the vague presentations of patients and allows situations to be handled appropriately.

**Conclusions**

The interplay between neonatal ethics and the experience and intuition of the provider is a unique aspect. As described above, these concepts can meld to create accordance between the patient, family, and health care team. The Intuitive-Humanist model provides proper, timely diagnosis following recognition of patterns and similarities, and ethical principles ensure the infant remains the focus of our actions. To further strengthen the basis of a practitioners work a positive, honest philosophy that takes into consideration every aspect of care should be added. With these factors in place, excellence in care can be achieved.

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