



Commentary

Complexity and uniqueness in nursing practice: Commentary on Richards and Hamers (2009)

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Richards and Hamers (2009) aim in their paper to ‘consider the place of randomised controlled trials in nursing’. In doing so, they make a number of largely unsubstantiated observations about ‘those that reject the positivist approach to science’, assuming that ‘readers will be familiar with the case made by objectors’. In fact, the only source cited by Richards and Hamers for the arguments against RCTs is a paper I wrote seven years ago for a somewhat different purpose (Rolfe, 2002). As the sole named ‘objector’ to the RCT, I will attempt here to correct some of the unreferenced and unsubstantiated misconceptions that Richards and Hamers put forward in their paper, and then expand on the somewhat simplistic and one-dimensional position attributed to myself and other unnamed and unreferenced authors who have questioned the place of the RCT in nursing.

First, I do not ‘reject the positivist approach to science’, and nowhere in my paper which they cite as evidence of this view do I even mention positivism. What I have claimed elsewhere, however, is that whilst the positivist approach to science produces useful evidence for certain types of nursing interventions, the value of the ‘hard science’ paradigm for nursing is somewhat over-

stated (Rolfe, 2005). Second, I do not, and never have, subscribed to the view that ‘since the RCT is part of an explicit “medical” research paradigm, it has no place in nursing’. My position is that the RCT has a clearly defined role to play in nursing research, but due to some fundamental differences between the practice of nursing and the practice of medicine, its role is somewhat limited (Rolfe, 1999). I have also never suggested that ‘nurses do not “treat” patients’, which as Richards and Hamers point out, would indeed be a questionable assertion, but rather that nursing practice demands that we sometimes treat patients in fundamentally different ways from medical practice: that we treat them individually as *persons* rather than collectively as *people* (Rolfe and Gardner, 2005).

Richards and Hamers ultimately summarise all of these real and imagined objections to the use of the RCT in nursing research in a single issue, namely ‘that nursing is such a complex endeavour that it is impossible to identify the component elements of nursing and devise controls which provide meaningful comparisons’ (Richards and Hamers, 2009). It is somewhat ironic that, in their subsequent examination of the issue of complexity, Richards and Hamers have grossly oversimplified the many diverse and sometimes intricate arguments against placing the RCT ‘at the heart’ of evidence-based nursing. Furthermore, I would suggest that they have set up the ‘complexity’ argument as a straw man, an objection to the RCT that may or may not be advocated by some of their ‘objectors’, but which is relatively easy for them to refute. In fact, I would agree with them that complexity can be accounted for by the RCT, but I would suggest that it is neither the strongest nor the most important objection. Indeed, I will go further and argue that their ‘complexity’ thesis is based on the very questionable assumption that nursing practice can always be broken down into ‘component elements’ that are amenable to identification and measurement through the RCT, and suggest in its place an alternative proposition about the nature of nursing that

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challenges the pre-eminence of the RCT for the purpose of understanding and evaluating nursing practice.

Whilst it is true that *some* types of treatments can be arranged along a continuum from simple to complex, others are of an entirely different order that has nothing to do with complexity. By my account, nursing is not predominantly the administration of selected 'evidence-based' treatments, but is an ongoing therapeutic relationship between an individual nurse and an individual patient that is influenced by the time, location, context and innumerable other variables in play at that precise moment in that precise setting (Rolfe, 1998). It is not merely that this is a *complex* nursing intervention, but that it is *unique*: what might be seen as ostensibly the same interaction between the same patient and the same nurse on another occasion or in another setting might well produce a very different outcome. This is well recognised by many practising nurses and nurse theorists, who attest to the view that 'nursing consists of interactions between unique individuals, with unique experiences, and it always takes place in unique situations' (Sarvimaki, 1988). To suggest that these are 'complex interventions' capable of being broken down into their 'component elements' is to misunderstand the nature of the nursing intervention. The unique nurse–patient encounter that characterises much of the therapeutic work of most nurses is not some 'degree zero' or ultimate level of complexity that could be accounted for, measured and even predicted if only we could isolate and identify the many variables at play; it is something of an entirely different order 'which no amount of rules and facts can capture' (Dreyfus and Dreyfus, 1986) and which the logic of the RCT was not designed to account for.

It is thought that the RCT was initially developed for agriculture as a means of testing crop treatments (Fisher, 1949) and was later adapted for measuring the effectiveness of drugs and other medical interventions. The logic underpinning the RCT assumes that the response observed in a carefully selected sample will be replicated in the population which that sample represents, and again (within certain pre-calculated limits) in any individual member of that population to which the treatment is administered. This logic relies on every plant in a crop responding to a treatment more or less identically, and assumes that the goal is to maximise overall crop yield rather than with the wellbeing of individual plants. Similarly in medicine, the assumption is that, within specified limits, all patients will respond physiologically in much the same way to the same dosage of the same drug, and again the focus is to maximise (cost-) effectiveness at the level of the population rather than the individual.

When applied to nursing, there are a number of interventions (even complex ones) where all (or nearly all) patients can be expected to respond to treatment in more or less the same way regardless of the context of the intervention, or where there are a manageable number of extraneous variables that can be accounted for. There are yet other situations, particularly in the field of epidemiology, where the general response of the population is of greater relevance than the response of individuals. In these

situations, the RCT is without doubt the methodology of choice for evaluating the effects of such treatments and interventions. However, I have suggested that not all nursing interventions follow these assumptions. Whilst we can regard patients as a more or less homogenous if somewhat complex group for the purposes of certain nursing interventions, much of the therapeutic work of nurses does not fit this medical or agricultural model which regards patients as variations on a general theme or where the population rather than the individual is the unit of measurement.

Unfortunately, Richards and Hamers appear not to recognise this point, claiming at the very outset of their paper that 'The randomised controlled trial (RCT) is at the heart of the evidence-based medicine movement and by implication should also be central to evidence-based nursing', and stating elsewhere that 'RCTs are part of an epidemiological research tradition'. It is unclear quite why Richards and Hamers believe that the gold standard methodology for medicine should 'by implication' also be the gold standard for nursing unless it is assumed that the practice of medicine and the practice of nursing are essentially one and the same. Similarly, the fact that the RCT is the methodology of choice for epidemiological research is only relevant if nursing is considered to be concerned primarily with populations rather than with individuals; that is, as task-centred rather than patient-centred.

Clearly, I do not share these assumptions. I have argued that there are very many situations in nursing practice where macro-level statistical generalisations about *people* are of no help in our micro-level understandings of individual and unique *persons*. To focus solely on what Richards and Hamers refer to as the 'component elements' of nursing is to disregard a vast amount of what nurses do; more than this, it is to misunderstand what nursing *is*. A great deal of the therapeutic effect of nursing happens not during 'treatments', but is continuously mediated through the minute-by-minute and day-by-day interactions between the individual nurse and the individual patient. Furthermore, I have suggested that attempting to understand these therapeutic interactions is not merely an issue of complexity that can be resolved through refinements to sampling, data collection or statistical analysis. Therapeutic relationships are not merely more or less complex examples of a general and measurable nursing intervention, they are unique instances that need to be understood in very different ways. That is not to say, as Richards and Hamers suggest, that I believe that the RCT *has no place* in nursing, but that the RCT should *know its place* in nursing.

Conflict of interest

None.

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