

Essence of informed consent nursing essay



The relationship between a doctor and a patient today is based on the principle of freedom of choice (of doctor, treatment type) which is characteristic of informational relationship model. A new concept has replaced the previously prevailing in medical practice paternalism, when doctor individually, not considering patient's opinion, made the decision on the examination and treatment.

In the modern system of doctor-patient relationship, a patient's right to voluntary informed consent plays an important role. Informed consent, which is a prerequisite for any medical intervention, is a patient's voluntary acceptance of treatment after being sufficiently informed by the doctor.

The process of obtaining informed consent can be divided into two stages: 1) providing patient with information on the basis of voluntariness and competence and 2) the getting and proper registration of the patient's consent (Cohn & Larson, 2007).

Under the current law a patient has the right to be fully informed (Hoeyer, 2009):

about his or her health status (including medical indicators of that state);

about the doctor's assumed actions, potential risks and benefits of each procedure;

about alternatives to the proposed treatment;

about the diagnosis, prognosis and course of treatment.

When informing a patient, particular attention should be given to the possible risks associated with the course of the recommended treatment.

In addition, to make conscious decisions about medical intervention the patient has the right to consult with a disinterested person and get an additional independent opinion on the state of his or her health. The patient also has the right to obtain information about the professional qualities of the person providing medical aid or special care, about the rules that the patient must follow when undergoing treatment and immediately after. The data provided to the patient by the doctor should contain all the necessary information (Schenker, 2011; Sugarman, 2005).

Taking into account the principle of voluntariness of obtaining information, the patient has the right to refuse from receiving information about his or her health status or indicate a person who should be informed instead (Felt, 2009).

When informing, an important issue is the patient's competence and ability to understand the received special medical information. Obviously, information should be communicated to patient in a way consistent with his or her ability to comprehend. It should be differentiated depending on patient's individualities and specific circumstances (general health state, educational level, etc.). Explaining the nature of the forthcoming treatment to the patient, it is desirable to use a minimum of medical or technical terms. If necessary, an interpreter should be provided for adequate communication and perception of information about treatment by the patient (Cohn & Larson, 2007).

At the time of receiving the information the patient should be able to perceive it in order to make conscious decisions about voluntary consent to medical intervention. Informed consent means that the decision should be made on patient's own free will without such external factors as coercion; deception; threat; career, financial or other dependency (Cohn & Larson, 2007; Sugarman, 2005).

The obtained patient's consent to medical intervention should be properly recorded. The current law on health care does not provide as a norm a written form of consent, but since getting informed consent is regarded as the right of the patient and therefore implies corresponding obligations of the doctor, the written form of consent is advisable as evidence of doctor's execution of his duties. In case of a court issue or a conflict between patient and doctor, the written informed consent of the patient will guarantee objective consideration of the dispute.

Literature review

In medical literature, an opinion is expressed that informed consent is a doctor's means of legal protection, greatly weakening patient's legal position and not representing his or her interests fully.

Any treatment carried out without patient's informed consent is considered illegal, and if it causes harm, the question of obtaining a refund is solved uniquely. The situation changes when a damage occurs after fulfilling the obligation of providing the necessary information to the patient and obtaining the consent. In this situation the plaintiff-patient has to prove the relationship between treatment and harm beyond the limits of informed

consent, or disclose the poor quality, insufficiency, or incompleteness of information, only in this case his or her verbal or written consent loses its meaning (Cockcroft, 2009; Felt, 2009; Sugarman, 2005). The current court practice of the dispute between patients and hospitals fully confirms this thesis.

The problem can be solved by developing a certain standard of informing a patient about each type of medical intervention taking into account the existing medical standards for the provision of various forms of aid (Cockcroft, 2009). Standard of informing and the unified form of the document for this type of medical intervention can help to prevent or significantly reduce the number of legal disputes over the insufficiency and incompleteness of information provided to the patient. The lack of standard of informing the patient and the unified mechanism of regulation of issues related to its obtaining and registration prevents both the full implementation of the respective rights of a citizen and the protection of medical employees in case of conflict situations (Hoeyer, 2009).

Moreover, in recent years a lot of information has appeared that team paternalistic attitude to the patient reduces the effect of therapeutic measures, that openness and collaboration between doctor and patient in making treatment decisions increase patient's chances to survive even with the direst diagnoses, including cancer (Cohn & Larson, 2007; Schenker, 2011). There is an article (Cunningham & Watson, 2004) about the married couple of Simontons, the administrators of Dallas Cancer Center, who have achieved obvious success in treating malignant tumors by developing in patients the attitudes and belief in the possibility of nonspecific treatment of

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physiotherapy and occupational therapy. Practicing since 1971, the authors of the method managed in 63 out of 159 people condemned by the official medicine to maximum of one year of dying to completely remove the cancer stress (still alive), and help others to at least double their life span making it 24. 4 months against 12 in the control group of patients treated by standard methods. That is a polar case of a high efficiency of cooperation of doctors and patients (Cunningham & Watson, 2004).

Due to the increasing number of lawsuits related to poor-quality medical care, unfavorable outcome of medical intervention, many hospitals are developing their own form of the document that displays the patient's consent to medical intervention. Practice shows that the most commonly proof of voluntary consent of the patient to medical intervention is registered in case of delivery paid medical services or performing complex interventions, as well as in outpatient clinics that provide dental care. Lately, the principle of informed consent has been actively used in carrying out such interventions as preventive vaccinations.

Further, we'll analyze the concept of informed consent, figuring out its main elements and effects, as well as discuss the implication of the concept in nursing practice.

Antecedents, attributes, and consequences of the concept of informed consent

The concept of informed consent was born in the fight against paternalism in the relationship between doctor and patient when it was believed that the doctor was all-knowing, wise, stern father, and the patient was an innocent

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child, who should unquestioningly obey the opinion of elders. Its appearance is associated with two global processes: the development of universal human rights, when with increasing educational and cultural level of the population each individual as a personality has become aware of his uniqueness and value, and the dissemination of market relations in the sphere of medical care, when a doctor gets into the position of the person who sells medical service, and the patient – the person buying it (Sugarman, 2005).

The bargaining parties are legally equal. In these circumstances, the seller (doctor) should prove himself that the choice made for the patient is the best available and be able to convince the buyer (patient), conveying his own logic of decision in a way that the latter would understand and believe that doctor's actions are intended to cure, rather than just pulling the money. Thus, the risk is shared between the parties: the doctor puts his reputation and professional responsibility at risk, and patients put their health and sometimes their life.

In general, the concept of informed consent derives from the general concept of individual rights, formulated at the beginning of the century. In particular, it refers to the right of a free citizen (the first and superior to other rights) to the inviolability of his personality, the right to himself implicitly recognized by all the rest (Steinberg, 2009). This law prohibits a doctor to break out his patient's bodily integrity without having the permission. By this we mean that the patient is a person who will continue to live after medical penetration with all the consequences produced by it. And there is no legal obligation to the patient to accept the proposed treatment;

in addition, laws do not mention that the patient can be subjected to any curative effects without his informed consent.

The rights of doctors also do not include mandate to treat someone who is in need of treatment just in the opinion of doctor. The work of a doctor is certainly complicated by the conditions of the legal protection of personality, but the lack of such protection is not good too. For example, a Muslim fundamentalist will die of the idea that he was poured another person's blood when he was in a severe coma, and his relatives will regard it as lethal sacrilege.

Thus, the doctrine of informed consent lies in the fact that before the doctor asks the patient to give consent on implementing an individual course of treatment or procedures that are risky, but have alternative options, especially where the chances of success are low, the patient must be provided with the following information (Cohn & Larson, 2007; Hoeyer, 2009):

- what the proposed procedures are, and what they involve;
- what the risks and benefits of recommended measures are, specifically emphasizing the danger level of the most adverse outcomes (death or severe disability);
- what alternative ways of treatment and their risks are;
- what will happen if a patient do not start or delay treatment;

- which the probability of success is and what kind of success is expected by the doctor;
- what possible difficulties and duration of rehabilitation are;
- what other related information can be provided (answers to patient's questions, posing similar cases from doctor's experience, etc.)

The patients are to be informed about the serious risks that increase their liability in the choice of consent to treatment or alternative treatment or in the direction of the full withdrawal from it. For example, the probability of death 1: 10 000 should be mentioned, and the probability of postoperative non-threatening complications may not be mentioned.

From a legal point of view, the doctrine increases patient's self-involvement and self-determination in decision making and thus, increases its validity.

The market "buyer-seller" relations are supplemented by the specific component of personal trust of the patient towards the doctor. The patient believes that the doctor gives him the full amount of information needed for the success of treatment. Thus, the relationship may assume the character of paternalism: the patient entrusts his fate to doctor at a level children entrust themselves to the care of parents. But this is no longer the same command paternalism that was specific for the past soulless administrative management systems.

Still, a lot of discussions are focused around the question on how often patients need to be asked for permission. Courts consider that patients are to be asked in all cases fraught with any serious complications, infection,

changes in appearance, etc. For example, a pregnant woman was treated by a dermatologist on a case of spots on her face. The doctor applied the traditional methods, without considering pregnancy, and the spots became more vivid on therapy. The court found the doctor guilty, as he did not see a serious reason for treatment and exposed a pregnant woman to unnecessary risk. First of all, courts ask their experts how necessary the treatment was and whether it did not involve additional risks which could be more significant than the expected success (Walker, 2008).

Lawyers also in all cases try to find out whether the patient's consent was competent, voluntary, and based on clear information.

The problem the competence of concerns both parties. The doctor should not go beyond his competence in explanations. For example, the risk for complex anesthesia should be explained by an anesthesiologist. At the same time, every adult patient should a priori be considered legally competent listener, if he has no restrictions on capacity and is not under the acute influence of alcohol, drugs, etc. The question of the competence of the decision often arises in cases of deliberate incompetence of patients (children, persons found legally incapable because of mental disorders, moronity, senile dementia, etc.). Here, a decision is made by the same schemes with the participation of parents or guardians. For example, regarding homelessness people, the decisions are made by specially authorized social workers. If the family or of the guardianship have no consensus, the question of a single custodian is decided by court (Steinberg, 2009).

Voluntariness lies in the fact that when making decisions, especially when signing a written consent or refusal, the patient was not subject to any external pressure (threats, bribery, onerous financial terms). Understanding of the provided information can be difficult to prove, which in judicial practice is known as an example of denial of earlier given evidence. Often the patient finally remembers that the choice was made by him voluntarily (Felt, 2009). But if the doctor initially failed to reconcile the expectations of the patient from treatment with the possibilities of modern therapy, it becomes difficult to resolve such conflicts.

There are 4 main cases when the doctrine of informed consent may not be applied:

1. In case of emergency care, where any delay threatens the life or preservation of the health of the patient;
2. If the risks are negligibly low and are well known to all the citizens (e. g., risks of blood test);
3. If the patient knowingly refuses to listen to information about the likelihood of death or severe disability (such a refusal is preferably set down).
4. If the doctor believes that the patient cannot psychologically bear the informational trauma from the message on the discovered disease or health state. In this case, the doctor should ask the patient to whom he entrusts the discussion of health problems and future treatment. In modern terms, this occasion is resorted rarely.

It would also be wrong to introduce the patient to treatment, allowing him to read professional literature (Schenker, 2011). Such reading could cause “ the effect of Mark Twain”, who, reading the Encyclopaedia Britannica, discovered he had all the diseases, except for puerperal fever. Besides, the language of medical literature is complicated for an average patient. It can only complexity the understanding of what the patient has to move through and what results he has to wait for and when.

However, hospitals and clinics have an internal profilization, and for each doctor, there is a small collection of some standardized technologies and procedures, the description of which is easy in the framework of adopted treatment schemes and within the language understandable to an average literate competent patient. In these booklets of internal use, a patient can find the information on risks, alternatives, and consequences of refusing from treatment. Literate patients are provided with booklets and others come through interviews with nurses (Cohn & Larson, 2007; Schenker, 2011).

Conclusion. Implications for nursing

Nursing personnel makes up the largest category of health workers, and the effectiveness of health care institutions largely depends on their professional knowledge and skills.

Important functions of the nursing staff are informing patients about their rights and responsibilities when receiving medical aid, about medical interventions conducted by nursing staff including information about the

associated risks, options for medical intervention, their consequences and outcomes of treatment (Higgins & Daly, 2002).

Discussing situation with the patient and possible ways of its improvement, the nurse should consider the significant point that the patient has the right to accept or reject the suggested treatment and care after receiving the necessary information. Therefore, he should be informed about everything that happened to him, everything that will be done, that he himself or his relatives will have to do, and give the consent. Further, the plan can only include the problems, goals and interventions agreed by the patient. It is desirable that the informed consent of the patient was recorded in nursing documentation. In our case the patient cannot speak, but he understands everything and can by any gesture confirm his consent. The nurse must not only respect the rights of the patient but also tell him about his rights (Higgins & Daly, 2002; Informed consent for research in critical care: implications for nursing, 2006).

The nurse should write down all nursing interventions, actions on addressing the problem, into a report (usually on the reverse side of the page with the plan). This helps to monitor the activities of nurses and to provide continuity, so that the next shift nurse knew what has been done and what needs to be done. The plan of nursing interventions is made by the nurse, who was on the shift when the patient arrived, but during a shift of some other nurse some additional problems may occur. Then the nurse formulates goals and nursing interventions, and inserts an extra sheet into the folder kept for each patient. If the problem is solved, the corresponding sheet is replaced to the bottom of the folder (Ulrich, 2010).

It is recognized around the world that the quality of health care depends not only on doctors, but also on the professional nursing care. Therefore after discharging a patient, all the documentation on the nursing process is stored in the archive together with patient record. It is desirable that a patient had a copy of the plan of nursing interventions, so that he could estimate progress on the way to recovery. In any case, the nurse should discuss the situation with the patient and his relatives, show positive changes, etc.

(Higgins & Daly, 2002; Ulrich, 2010)

In any case, nursing interventions can be very diverse, but one of the major responsibilities of nurses is to clarify the patient's understanding of purpose and progress of the upcoming treatment and his consent to the procedure.

In general, the doctrine of informed consent is the most modern form of the union of medicine with the people, the reflection of the most humane inclusion of medicine for the benefit of living, constantly renewing humanity. Only the further development of the principle of voluntary informed consent to medical intervention, its wide application in medical institutions can help to protect the legal rights and interests of both patients and medical professionals.