Consent and informed consent nursing essay

The Mosby pocket Dictionary of Medicine, Nursing and Health Profession defines consent as, permission given by an individual acknowledged as legally competent. Informed consent is a requirement necessary prior to any invasive procedure to be performed.

Simpson (2011) highlights consent is permission given by the client for a procedure to be implemented. While, Wilhite (2010) explains that informed consent is a process where clients' are informed of the risk, benefits and alternative treatment empowering client to play a part to make informed and autonomous decisions proceed for the treatment.

As demonstrated by Hall et al. (2012) informed consent encompasses and intersect three different concepts; ethical, legal and administrative factors. Ethically, it safeguards and supports the autonomous decisions made by the client. Hereby, Bosek and Savage (2007) and Rumbold (2002) cites Gillon (1986) defined autonomy as a major ethical principle based on respect for an individual who is capable to think and decide independently for informed choices. Legally, it acts as defence against assault or battery as also supported by Staunton & Chiarella (2008). Lastly, administrative purpose ensures that ethical and legal aspects of informed consent are implemented and appropriately documented.

In the writer's opinion, most sourced definition and concepts are consistent and capture the overall essence of informed consent. However, the definition of informed consent from Mosby pocket Dictionary of Medicine, Nursing and Health Profession lacks the knowledge of information giving and only pointed

to invasive procedures. As much as possible, informed consent in nursing procedures should also be included.

Consent differs from informed consent. Consent is the act of asking approval to proceed onto a procedure. Conversely, informed consent is a process in which all information relayed is understood by the receiver and decides independently. The act of securing an informed consent is to protect clients' rights which resemble the ethical principle of autonomy and avoid any legal ramification to the nurse (Wilhite, 2010). As practicing nurses, we should act as advocates, and build rapport with our client to facilitate the process of obtaining informed consent; Tschudin (2002) affirms that it is also a caring act that involves connecting one another.

The next few paragraphs, the professional, ethical and legal drivers will be identified and explained. Professional drivers for nurses are indicated in the professional code of ethics and conduct. It serves as platform for self-regulation, a professional responsibility to ensure that the right and quality duty of care is carried out (Bandman and Bandman, 1995). This corresponds with the ethical theory of Deontology, Thompson et al. (2006) refers Deontology as actions that is based on duties, principles and duties. His view is further reinforced by Bosek and Savage (2007), which emphasise that ones' moral duties and responsibilities act is consistent with the right actions.

In the Singapore Context, the Singapore Nursing Board (SNB) Code and Ethics and Professional Conduct (1999) value statement 2 states " Nurses shall respect the clients' right for self-determination and provide them with

whatever information they require to make informed decisions concerning their own care". It accentuates ethical principle of upholding autonomy of the client when nurses are securing informed consent. Staunton & Chiarella (2008) adds that when a client is asked to give consent to treatment, the nurse is compelled to provide sufficient information.

In value statement 2. 4, it says " nurses should obtain consent for nursing intervention where necessary and collaborate with other members of the health care team to obtain consent for medical treatment. When client are incapable to make informed choices, consent should be sought from family members or significant others". The holistic process of securing an informed consent is encouraged and to be obtained from relatives if otherwise. However, McHale (2009) argues if an adult client ability to decide is deficit or without any represented decision maker; that is appointed by the court or client himself, treatment can proceed in the client best interest and minimise harm caused. This resembles the ethical principles of beneficence and non-maleficence. Beauchamp and Childress (2009) refer beneficence and non-maleficence as acting for the benefit of others following a moral duty and the act of not causing any form of harm.

In the context of United Kingdom (UK), the Nursing and Midwifery Council (NMC) Standards of Conduct, Performance and ethics for nurses; Regulation in Practice (2012) declares the regulation of consent taking comprises various aspects of situations, issues and policies. Situational events such as emergencies, issues concern with refusal of consent by competent or incompetent client and minors under age of 16. Lastly, policies of the Mental

Health Act, Mental Capacity Act (2005) are incorporated. It embodies the ideal guidelines and procedures of obtaining informed consent.

The writer infers SNB say on informed consent taking as ambiguously written, In terms of the choice of words used such as “ whatever information” and “ where necessary”. The writer argues against that “ whatever information” may be misleading on how adequate is “ whatever information” to be disclosed and “ where necessary” is to abide by the convenience of the nurse or clients rights. Conversely, the writer remarks that NMC consent taking procedures are specifically and descriptively written in every section on the regulation. It is used to assist healthcare professional when faced with any moral dilemma or uncertainty. Both professional code of ethics and conduct stresses on the ethical principle of safeguarding autonomy of the clients’ and protects the nurse against liability of torts.

Legal drawbacks related to failure to obtain informed consent may be imposed to the healthcare professionals and face the following claims; battery and/or assault and false imprisonment (Staunton & Chiarella, 2008). Fleming (1998) as cited by Aveyard (2002) defines battery and assault as deliberately touching, inducing harm, injury or offensive contact to a client without clients’ consent. False imprisonment is defined as individual is physically detained from leaving the place (Kelly, 2011).

Following a given example, battery may be claimed towards Nurse Jane when she performed a sponge bath intentionally, when the competent conscious adult client who is on complete rest in bed order has refused it. Ethically, Nurse Jane has applied the principles of beneficence, that it is her

client best interest that she feels clean fresh after sponge bathing. However, clients' autonomy was tempered by not allowing her time to decide and Nurse Jane forced a treatment in contradiction of clients will. Thus, contributing to the liability for tort of battery.

In this instance, Nurse Jane has also committed a Paternalistic act. Rumbold (2002) outlines Paternalism as the decisions and preferences of the client are ignored and clinicians act on behalf of the client. The autonomy and beneficent act may conflict and risk becoming a paternalistic act.

To prevent paternalism, several writers, (Simpson 2011; Slowther 2007; Aveyard 2002) implies that healthcare professionals should respect clients' autonomous rights when treatment is refused even so, if it leads to death. As a practicing nurse, Jane should adopt the caring act and gradually give details about the nature of the intentional procedure. Allowing the client time to decide and promote autonomy.

The tort of false imprisonment can be liable to the nurse when a competent client is not committing harm to self or others is detained without his consent (Kelly, 2011). It is similar to a situation whereby a nurse falsely imprisons a competent adult client to the bed raising the side rails of the bed preventing him from getting off the bed without his consent.

However, Staunton & Chiarella (2008) debates in a contrasting situation whereby after approaches to decrease hostility and violent in an incompetent client failed, the use of restraints are allowed without his consent to protect him and others from potential injuries. The clients' next of kin and physician in charge needs to be informed of the reason why he is

being restraint at that point of time. It is essential that nurses documents the incident to prevent any liability for the tort of false imprisonment or battery.

Moving on, the writer explains how informed consent is obtained and criteria for informed consent to be met via an illustrated example of Nurse Kelly, practising on the surgical floor and had been ordered to insert a urinary catheter for her competent adult client.

The criteria(s) that should be met when obtaining consent are; client retains the mental capability to make legal decisions, information given by client is suitable and satisfactory. Lastly, client willingly consents without external pressures or coercion (Thompson et al. 2006).

Insertion of urinary catheter is an invasive nursing procedure involving a piece of foreign body into the anatomy of the client. Before commencing on the procedure, Nurse Kelly should alley anxiety of the client by introducing herself; gradually explain the purpose, risk, benefits consequences for inserting the urinary catheter and any reasonable alternatives that is available (Wilhite, 2010). Allowing her some time to decide and make the informed choice. Hence, Nurse Kelly is promoting clients' autonomy by allowing client to make optimum decision in the best interest of the client.

Nevertheless, Nurse Kelly clients' may choose to refuse treatment. Hall (1996) supports, nurses are ' offering' the freedom to refuse when permitting client the autonomy for consent to treatment. This situation often causes great stress and dilemma to the nurse as she has the duty carry out the care to safeguard her client from harm and at the same time, to respect her clients' autonomy and the right to refuse. To resolve this dilemma, Nurse

Kelly may want to view the decision to refuse, from her clients' perspective and the reason for refusal of treatment (Slowther, 2007).

At this present times, Chavarriaga (2000) and Cole (2012) admit that the use of implied consent is commonly implemented within the nursing practice. Cole outlines Implied consent as the behaviour of the conscious client is consistent with the nursing procedure that is about to be implemented. It is recognised that the ' usual nursing procedure' such as taking vital signs seen as non-invasive and quick procedure that would not cause any potential harm.

However so, the practice of implied should be discourage as much as possible so as to protect patient autonomy and promote meaningful decisions and prevent potential battery can be imposed to the nurse for unrightfully touching. Obtaining informed consent for nursing procedures often seen as a rigid process (Aveyard, 2002). Therefore, as much as possible, it is a better practice in clinical area to practice obtaining informed consent prior to any nursing interventions to uphold the professional obligations as practicing nurses.

In a true emergency situation it is an exception area whereby obtaining informed consent is withheld as supported by these writers (Simpson, 2011; Michael, 2002; Chavarriaga, 2000; Hall, 1996). In this exceptional case, consent taking is implied as the ethical principle of beneficence and non-maleficence is prioritised over clients' autonomy. It is the Doctrine of necessity where immediate treatment is necessary to preserve the life and

prevent harm to the client and it is assumed that client would consent if able to do so (Staunton & Chiarella, 2008)

In another situation, Michael (2002) insists that when client is scheduled for a surgical procedure that is being done by the physician. It is the responsibility of the physician to secure a written informed consent and not the nurse. As argued by Michael, nurses play a part as a witness and clients advocates during the process of informed consent taking with the physician.

Beforehand, nurses could assess for outstanding impairments or limitations such as; language barrier or hearing impairments that would be a hindrance to clients understanding during the process of informed consent (Wilhite, 2010). These are initiatives taken by the nurse to assist and encourage clients' autonomy.

On balance, literatures referenced are in favour for nurses playing a major role in securing informed consent (Wilhite, 2010; Chavarriaga, 2000; Simpson, 2010; Aveyard, 2002; McHale, 2009; Michael, 2002 & Hall et al., 2012).

Legal nurses (Wilhite, 2010; Simpson, 2010 & Michael, 2002) who authored the literatures emphasise and define on the major role of nurses securing informed consent, Philosopher (Aveyard, 2002 p. 243) reaffirms that nurses are required to obtain informed consent prior to nursing care as she views that " nurses should not be mechanistic but should be determined by the need of individual patients".

Finally, this essay has explained the central importance of whether nurses should or should not play a key role in securing an informed consent. The writer for one believes that nurses should play a major role to secure informed consent for nursing procedures to a greater extend. We are compelled as it is stipulated and articulates in the SNB and NMC code of ethics and conduct. When informed consent is obtained, it acts as a safeguard against legality issues; battery and false imprisonment. However nurses may be faced with obstructions such as time constrains and may choose to obtain implied consent instead. Nurses may face with dilemma when client abuse the freedom of choice and refuse treatment. In spite of those constrictions, in reality, nurses are bounded by guidelines to follow. Thus, nurses have to try their best to accomplish it.