Clinical nurses' ethical decision making in situations of informed consent

Based on responses to vignettes and semistructured interviews with 27 nurses working in two clinical settings, data were gathered focused on nurses' ethical decision making in situations of informed consent. A content analysis of the interviews revealed that the most potent variables at play in these situations were institutional and philosophical influences. Aspects of these influences are discussed.

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THE AMERICAN Nurses' Association *Code for Nurses*[1] makes it clear that a central ethical obligation for the nurse relates to the patient's right to know about his or her condition and to be told about the procedures undertaken for treatment or research purposes. The bioethics literature indicates that the physician and researcher have the primary ethical obligation to obtain informed consent from patients. While this statement reflects traditionally defined legal and ethical reality, it may not reflect the complexities of obtaining informed consent in clinical settings such as hospitals. This descriptive study, based on interviews with 27 nurses, draws from the data considerations bearing on the nurses' ethical dilemmas and behavior in situations of informed consent.

A convenience sample of 27 nurses working in a large medical center and a city hospital participated in the study. Both

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of the facilities serve as clinical, teaching, and research sites. Slightly more than half of the respondents (15) worked as staff nurses, while 12 worked as either head nurses or clinical specialists. They provided medical (15), surgical (5), pediatrics (5), and trauma (2) services. Seventeen had worked in their positions for five or more years.

INFORMED CONSENT

The informed consent doctrine remains essentially an ethical imperative that also has substantial foundations in law. Grounded in the ethical principle of autonomy, valid consent can be best conceptualized as a process of shared decision making based on mutual respect.[2] Autonomy in the case of patients means that they have the right to information and, on the basis of this input, the right to agree or to refuse to undergo the treatment being proposed or to participate in research. In addition to the principle of autonomy, the principle of nonmaleficence has a central focus in informed consent.[3] Cultural differences within a pluralistic society must not obscure the ethical position that people have a need and a desire for information, choice, and respectful communication about decisions.

Capron[4] has identified several important functions of consent: the promotion of individual autonomy; the protection of patients and subjects; the avoidance of fraud and duress; the encouragement of self-scrutiny by health professionals; the promotion of rational decisions; and the involvement of the public in promoting autonomy as a general social value.

The elements of informed consent have been divided into information elements and consent elements.[5] The former have to do with disclosure of information by the health care professional or researcher and the patient's or human subject's comprehension of information. Consent elements include the notion of voluntariness and competence to consent. Voluntariness connotes the patient's ability to choose his or her own goals and to choose among various goals when several are offered, without being unduly influenced or coerced by any of the alternatives by others. Competence, a precondition of acting voluntarily, is the ability to understand the situation well enough to make a decision about a specific question.

Traditionally, paternalistic behaviors of doctors and nurses have interfered in the informed consent process. Experts assume that they know what is best for the patient and, in so doing, can overreach their expertise. Nursing or medical expertise does not enable health care professionals to know the values of patients or what patients think is best for themselves.

Several studies[5-8] have pointed to problems in informed consent. Numerous articles[9-11] have raised questions about institutional review boards (IRBs), which review research to safeguard the rights of human subjects. Clinical ethics committees have been developed to assist in safeguarding patient autonomy and to examine situations when risk of harm is present. This bureaucratization of morals in health care still leaves the basic question of what values hold sway at the moment when the clinician or researcher approaches the patient for informed consent.[12] The question considered in this study is what nurses do or should do to meet their obligation to the patient in the consent process.

THE VIGNETTES

Vignettes have been used by social scientists and nurse researchers to measure broad concepts such as attitudes, beliefs, values, and perceptions.[13] While the vignettes used here are hypothetical, they are composites of actual cases and have been evaluated for validity by a panel of expert nurse clinicians.

Four treatment vignettes and four research vignettes were used specifically for this study. Each treatment vignette assumed that the treatment would have potential benefit to the patient. The research vignettes were similar to the treatment ones in the ethical issues raised, with the exception that the procedure was not necessarily beneficial to the patient.

In vignette 1, while talking with a patient, the nurse realizes that the patient does not understand the treatment procedure about to be undertaken and the possible risk, although she has signed the form. Vignette 2 describes a patient with a poor prognosis who is refusing treatment. The physician asks the nurse to use her well-established relationship with the patient to get her to change her mind and consent.

A five-year-old girl with osteosarcoma is the patient in vignette 3. The physician has told her parents that her leg should be amputated followed by chemotherapy and radiation and that there will be side effects and about a 15% chance of survival. The child does not want anything done. The parents ask the nurse caring for the child if she thinks they should consent to treatment.

Vignette 4 describes an 18-year-old girl with brain cancer who refuses all treatment. Her parents want her to receive all possible treatment. The physician is torn between the patient and the parents, since he thinks he can prolong the patient's life for about one year but is unsure as to her mental status. The parents turn to the nurse caring for their daughter and ask her to help them obtain consent from their daughter.

Each of the four research vignettes are similar except that the treatment is experimental and, therefore, there may be more clinical uncertainty and less or no benefit to the patient. Each respondent selected an option for action ranging from doing nothing to actively participating. Once a choice was made, comments about the ethical dilemmas and possible ethical behavior for each vignette were obtained through a semistructured interview.

THE FINDINGS

A content analysis of the interviews revealed that the most potent variables bearing on the nurses' ethical decision making in situations of informed consent for both treatment and research purposes were those of structural and philosophical influences. Structural influences included such considerations as type and location of institution, organization of work, institutional policies and procedures, and accountability structure. Philosophical influences refer to implicit epistemologic positions held by these nurses.

Structural influences

To a large extent, according to those responding, roles and responses of both

nurses and patients were constrained or patterned by the structure of the health care system. Such notions as "free choice" or "being there for the patient" were perceived as rarely possible because the system itself was not patient-centered, especially with regard to chronic illness. Things were often done for reasons other than the patient's best interest, and personnel became automatically implicated. For example, the full array of alternatives, especially alternatives that were seen as nontraditional, were rarely disclosed to the patient, thus constraining both the nursing role and the range of healing possibilities for patients.

Professional–client relationship

Hospitalized patients were seen to be generally noncritical of the system at an overt level. Their unquestioning compliance with institutional and medical authority compounded the nurse's role dilemma. For example, in situations of apparent physician impropriety, the nurse would often be hesitant to intervene unless the physician's action was experienced by the patient, or perceived by others, as damaging the vital human connection between the physician and patient. Therefore, the study identified a need for education of patients as to their situation, role, and rights before nurses could adequately perform their role functions and ethical obligations to the patient in informed consent situations.

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Job considerations

While job security was generally denied by this group of nurses as a realistic concern, variables such as time priorities and institutional hierarchy were perceived as important variables in considerations bearing on informed consent. An important factor was the psychological and moral climate influenced by the physician. Consistent behavioral differences among medical specialty groups were noted. The nurses perceived surgeons as essentially controlling of patients; others, especially oncologists, were generally perceived as cooperative with patients and staff. Research physicians were often seen as biased, manipulative, and presenting one-sided evidence or improper emphasis about procedures to patients. For example, research physicians were often perceived as accentuating benefits of experimental treatment to the patient while downplaying the known side effects. University physicians were seen as having lost perspective of who the patient is.

These perceptions led nurses to pattern their behavior around situations of informed consent accordingly, which led them to expect predictable responses from patients to these various specialists. Regardless of medical specialty, these nurses were disturbed by the physician's claims of authority and of superior expertise in areas where knowledge about both disease and treatment was uncertain. The nurses also felt that moral judgments by staff about areas of personal life and values

were unwarranted. Essentially, they did not view medical expertise as moral expertise.

Institutional considerations

At the most basic level of institutional influences are the degree and rapidity of patient and staff turnover. High turnover was not conductive to a climate in which relationships were developed, nurtured, and participated in by the patients and health care professionals. Lack of such relationships weakened the knowledge base of health care professionals about the patient as a person rather than only as a disease and, therefore, had a negative impact on informed consent as a process.

Another consideration was whether the institution was in the public or private sector. These nurses were of the opinion that physician control and autonomy were greater in private hospitals, where an unwritten code of deference on the part of employed staff seriously limited the extent to which the staff acted on their perceived obligation in informed consent situations.

In addition, the nurses believed that teaching and nonteaching hospitals experienced differences in patient and nurse behavior. In teaching hospitals, behavioral responses around such issues as informed consent were even more perfunctory than in nonteaching institutions. Patients often traveled to teaching hospitals from a distance so that the usual social support networks were not immediately available to them for consultation. Physicians who were assigned by authority rather than by choice often spent minimal time with patients, but they were considered the final authority on many problems for which they had little, if any, data or knowledge. Such data would include the patient's values and beliefs and the moral basis of the patient's questions and concerns. The physicians were viewed as also lacking in knowledge of ethical principles and moral reasoning.

Philosophical influences

The 27 nurses' approaches to ethical decision making in situations of informed consent depended, in large part, on their implicit epistemologic positions. In general, nurses with an empiricist orientation adopted relatively uncomplicated and fixed perspectives. They placed high priority on what appeared to them as scientifically based principles such as objectivity, rationality, statistical evidence, safety, and certainty.

Nurses with personalistic perspectives favored a more patient-centered obligation for informed consent. Priority was given to the patient as the major factor in ethical decision making and the need for the staff to imagine the perspective of the patient. They were prepared to analyze and interpret situations according to their particular properties or dynamics, and to shift role behavior accordingly. They relied on no one answer or specific strategy for reaching decisions.

Institutional safeguards

While the nurses often encountered various problems with obtaining valid informed consent from patients, they nevertheless were encouraged by the mechanisms that had been developed to safeguard this process. Peer review had

replaced no review or peer collusion and, while this was not totally adequate, it did provide more scrutiny than had been the case in the past. Additionally, since nurses had become more ethically sensitive to issues of informed consent, they had developed collective strategies for conflict resolution and dealing with interactions with patients and physicians. Such strategies as exposure of the conflict to the formal structure including the clinical ethics committee, neutralization of the conflict by providing needed information, encouragement, and psychological support had been used. Open and direct communication about the staff's uncertainty and discomfort, discussion of ethical perspectives, and the availability of skilled assistance for reaching solutions to ethical dilemmas were deemed necessary in many situations of informed consent, since they served as a safety net in problematic cases. The safety net of collective effort not only acts to safeguard the ethical decision-making process but also to help protect against legal actions. Another important built-in safeguard was the nurses' participation in relevant proceedings such as ethics rounds, IRBs, clinical ethics committees, and conferences that focused on bioethics.

IMPLICATIONS

While the ethics literature does not acknowledge the role of nurses in informed consent, nurses do, in fact, participate in this process. And from this participation, they have come to realize that the primary ethical and legal reason for informed consent, the promotion of patient autonomy, can be curtailed by structural arrangements in the hospital. A culture of values develops in hospital units that places boundaries of permissibility on the roles and functions of patients and nurses in informed consent. How nurses deal with problems that arise due to these structural influences depends on their philosophic orientation.

Informed consent is so central to biomedical ethics that we need to understand more fully the dynamics of it as a process. There is a need for more research on informed consent as it occurs in the clinical and research worlds of patients and health care professionals.

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