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Therapeutic Touch as an Ongoing Negotiation in Integrative Nursing: A Conceptual Framework for Bodily Boundaries, Changing Tolerance, and Withdrawal of Permission during Serious Illness

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Abstract

Therapeutic and caring touch can communicate presence, reassurance and attentiveness during serious illness, yet its ethical acceptability cannot be inferred solely from benevolent intent, prior agreement or the clinical value attributed to the intervention. Serious illness may alter sensory tolerance, communication, bodily vulnerability and the meaning that patients attach to physical contact. This conceptual and normative analysis examines therapeutic touch as an ongoing relational negotiation rather than a single authorization event. Drawing on contemporary nursing, palliative-care, dignity, autonomy, refusal and shared-decision scholarship, the analysis distinguishes initial permission from continuing tolerability and identifies the ethical significance of changing verbal and non-verbal expressions during an episode of touch. The central argument is that continuing permission should remain revisable throughout care. A patient may initially accept touch yet subsequently experience discomfort, uncertainty or a wish for contact to stop; conversely, reduced verbal communication cannot be treated as continuing authorization by default. The analysis develops a Continuing Consent and Bodily-Boundary Framework in which permission, tolerability, interpretation of changing responses, interruption and respectful alternatives are treated as related but analytically distinct processes. The framework does not establish a validated clinical protocol or numerical threshold for withdrawal. Instead, it clarifies the professional responsibility to notice boundary changes, preserve opportunities for withdrawal, accommodate communication differences and avoid converting relational familiarity into presumed bodily access. The resulting account positions therapeutic touch as a temporally contingent nursing practice whose ethical legitimacy depends on continuing responsiveness to the patient's present bodily and communicative situation.

Keywords: Therapeutic touch, Informed consent, Bodily autonomy, Palliative nursing, Relational autonomy, Patient dignity

Introduction

Touch has long been intertwined with the relational work of nursing. It may accompany reassurance, positioning, comfort, symptom support, personal care, physical assessment and moments in which verbal communication is limited or insufficient. Contemporary nursing scholarship continues to describe touch as a meaningful component of caring rather than as a peripheral technical act [1]. Yet the fact that touch can be caring does not settle whether a particular instance remains acceptable to a particular patient. Qualitative evidence from intensive care illustrates

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this ambiguity especially clearly: touch can convey safety, presence and human connection, while some forms or moments of touch may also be experienced as burdensome or distressing [2]. The ethical problem is therefore located neither in touch alone nor in a general presumption that touch is beneficial, but in the changing relationship between a specific bodily intervention and the patient's present willingness to receive it.

Nurses also use touch communicatively. In intensive-care nursing, caring touch has been described as a way of expressing attentiveness, trust and presence when words cannot perform the same relational function [3]. Integrative oncology services likewise incorporate manual and movement-based approaches into supportive and palliative practice, including professional training intended to make physical interaction more attentive and patient-centred [4]. Massage and other touch-based therapies are also studied in palliative cancer populations for symptom-related purposes [5]. These clinical uses make the consent problem practical rather than merely philosophical. A modality may have therapeutic intent and still become unwanted; a patient may appreciate one kind of contact and reject another; a previously welcomed intervention may become difficult to tolerate as fatigue, pain, dyspnoea, anxiety, cognition or sensory sensitivity changes.

Bodily contact can also implicate dignity independently of its intended clinical purpose. Recent concept-development work on sexual dignity discomfort identifies loss of control, embarrassment and unwanted bodily proximity as important features of patients' experiences in healthcare [6]. Therapeutic touch is not equivalent to intimate or sexualized contact, but the finding exposes a broader ethical principle: professional intention does not erase the patient's experience of bodily access. A nurse may understand an intervention as routine, comforting or clinically appropriate while the patient experiences the same contact as intrusive, exhausting or no longer acceptable.

This article therefore treats therapeutic touch during serious illness as a temporally extended ethical relationship. Its central question is not simply whether consent was obtained before contact began. The more difficult question is what should follow when permission, tolerance or communicative clarity changes after initial agreement. The analysis develops a Continuing Consent and Bodily-Boundary Framework that distinguishes initial authorization from continuing tolerability, recognizes withdrawal as potentially verbal or behaviorally expressed, and places interruption and communication accommodation within the ordinary ethics of touch-based nursing. The framework is proposed as a conceptual synthesis rather than an empirically validated protocol. Its purpose is to clarify what nurses may reasonably infer, what they should not infer, and where further patient-centred empirical work is required.

Background

Touch-based care takes place in a clinical context in which bodily vulnerability is often unavoidable. People who require assistance with washing, repositioning, mobility, procedures or comfort measures may need to surrender some practical control over space and bodily access. Observational research on assisted bodily care has shown that such dependence creates ethically significant tensions involving dignity, autonomy and responsiveness to changing wishes [7]. This does not make touch inherently problematic; it means that the moral character of touch cannot be separated from the conditions under which the patient receives it. During serious illness, the same action can be experienced differently depending on fatigue, symptom burden, privacy, trust, predictability and the degree to which the person remains able to influence what happens next.

Palliative nursing further intensifies this relational context because care often occurs when patients are increasingly dependent, symptomatic or aware of approaching death. Nurses working in palliative settings describe professional dignity in terms that include respect, relational attentiveness and sensitivity to the person whose body is being cared for [8]. A broad qualitative synthesis of dignity in intensive care similarly identifies autonomy, integrity, equality and environmental conditions as interconnected elements of dignified experience [9]. These findings are not interchangeable with consent research, but together they show why bodily tolerance cannot be treated as a stable background condition. Physical vulnerability changes what touch means because the patient may have fewer practical ways to reposition, disengage or leave the interaction.

The literature also resists a simple division between “beneficial touch” and “unwanted touch.” Nursing scholarship portrays touch as an enduring component of caring practice [1]. Patients, relatives and professionals may understand it as conveying security and human presence [2]. Nurses themselves describe communicative touch as a way of reaching patients through the body when ordinary conversation is constrained [3]. These positive functions matter because an ethics of continuing permission should not turn touch into something presumptively suspect. The more precise implication is that relational value and bodily authorization are separate questions. A caring intention can justify offering an intervention, but it cannot establish in advance that the patient will continue to welcome it.

A useful distinction can therefore be drawn among clinical purpose, relational meaning and current bodily acceptability. Clinical purpose concerns what the nurse is attempting to accomplish, such as comfort, assessment or assistance. Relational meaning concerns what touch communicates within the nurse-patient relationship. Current bodily acceptability concerns whether the particular person is presently willing and able to continue receiving the contact. These dimensions often align, but serious illness creates circumstances in which they may

diverge. A patient may appreciate the nurse and understand the purpose of care while becoming unable to tolerate further touch. Conversely, a patient may remain physically tolerant but prefer less contact because of embarrassment, fear, cultural expectations or a desire to preserve bodily control.

This differentiation also protects against reading tolerance from stillness alone. A severely fatigued or dependent person may remain passive because resisting requires effort. Another patient may accept a necessary procedure without positively wanting it. Still another may become uncertain after contact begins. None of these possibilities establishes a universal interpretation. They instead reveal why touch requires a temporal perspective in which the patient's current response remains ethically relevant after initiation.

The distinctions developed in this background are consolidated in **Table 1**. The table separates dimensions that can coexist within a single episode of touch and therefore should not be collapsed into a single judgment of whether contact is "appropriate."

Table 1. Distinct dimensions shaping the ethical acceptability of touch-based nursing care during serious illness

Analytical dimension	What is being assessed	How it may become visible in practice	Why it remains distinct	Boundary against overinterpretation
Clinical purpose of contact	The nursing or supportive reason for initiating touch	Explanation of comfort, assistance, assessment or symptom-related intent	A clinically legitimate purpose explains why touch is offered but does not determine whether it remains acceptable	Therapeutic intention must not be treated as continuing authorization
Relational meaning of touch	What physical contact communicates within the nurse-patient relationship	Reassurance, presence, familiarity, attentiveness or perceived intrusiveness	Relational meaning may be positive even when bodily tolerance changes	Familiarity does not create unrestricted bodily access
Bodily vulnerability	The patient's dependence, physical exposure and ability to control proximity	Need for assistance, reduced mobility, weakness, fatigue or intimate care	Greater dependence can reduce practical opportunities to resist or disengage	Passivity cannot automatically be interpreted as willingness
Current tolerability	Whether the specific contact remains bearable and acceptable in the present moment	Verbal reports, changes in posture, withdrawal, tension, facial expression or reduced engagement	Tolerability can change after contact begins even when initial permission was genuine	No isolated behavioral sign is a validated consent or distress threshold
Dignity and bodily control	Whether the person retains a meaningful sense of respect and influence over bodily access	Opportunity to prepare, request modification, pause, stop or choose an alternative	Dignity concerns extend beyond symptom relief or completion of the nursing task	Completion of clinically indicated care does not automatically demonstrate dignified care
Communication accessibility	Whether the patient has a workable way to express continuation, uncertainty or withdrawal	Speech, gesture, movement, communication aids, pacing or supported clarification	Communication limitations may obscure preference without eliminating it	Reduced verbal output must not be equated with continuing consent

Ethical foundations

The ethical foundation of touch begins with consent, but the relevant account of consent during serious illness must be more nuanced than a single choice made at one point in time. End-of-life ethics increasingly recognizes autonomy as relational: choices are made within relationships, illness trajectories and social conditions rather than by isolated individuals abstracted from dependence [10]. Similar arguments in advance-care-planning scholarship emphasize that chronic and serious illness can expose the inadequacy of treating autonomy as fixed, purely individual and temporally stable [11]. Relational autonomy is important here because therapeutic touch frequently occurs inside an established caring relationship. The nurse may know the patient well, anticipate preferences and adapt communication effectively. What relationality cannot do, however, is convert professional familiarity into ownership of the patient's bodily boundaries.

Empirical nursing research on informed consent supports this distinction. Nurses report that consent before nursing procedures cannot simply be presumed, although implied consent may sometimes be appropriate in ongoing care when adequate information, context and opportunity for refusal are present [12]. This is especially relevant to ordinary touch, where demanding formal verbal permission before every brief contact could become artificial, burdensome or inconsistent with the patient's own preferred style of interaction. Continuing consent

therefore does not require continuous ceremonial re-consenting. It requires that the original permission remain defeasible: the patient must retain a practical opportunity for the meaning of "yes" to change.

Professional power makes this requirement more important. Analyses of nurse-patient relationship boundaries show that nursing relationships contain asymmetries in knowledge, authority and practical control [13]. In home-based care, nurses also encounter situations where respect for autonomy conflicts with perceptions of safety, care obligations or professional responsibility [14]. These tensions demonstrate why bodily boundaries should not be understood as a simple opposition between patient preference and nursing beneficence. Nurses may reasonably believe that an intervention is helpful, necessary or protective. The ethical problem arises when that belief becomes a reason to discount new evidence that the patient no longer wants the contact or cannot comfortably tolerate it.

The patient's participation may itself be difficult to interpret. Conceptual work on constrained participation identifies ethically ambiguous situations in which vulnerable people participate neither fully freely nor simply involuntarily [15]. Relational nursing research likewise shows that autonomy is often supported through adaptation, collaboration and responsiveness rather than by leaving patients alone to exercise abstract independence [16]. Fine-grained analysis of nurse-client interaction further indicates that conversational sequencing can make a person's readiness more or less visible [17]. Taken together, these studies support an important distinction for touch-based care: assent, participation and tolerability should not be treated as interchangeable evidence of continuing permission.

Assent can mean an initial expression of willingness. Participation can mean cooperation with what is happening. Tolerability concerns whether the ongoing experience remains bearable and acceptable. Continuing permission concerns whether the nurse still has an ethically defensible basis for proceeding with that specific form of bodily contact. A patient may assent initially and participate passively while becoming increasingly uncomfortable. Another may tolerate contact while simultaneously wishing that the intervention would end sooner. A person who has difficulty speaking may communicate clearly through movement, expression or withdrawal; another may show ambiguous behavior that cannot safely be translated into a definitive preference without clarification.

Nonmaleficence adds a second layer. Harm in this context need not mean physical injury. It can include unnecessary distress, humiliation, loss of bodily control or the experience of being handled after one's willingness has changed. Relational trust is relevant because patients may depend on nurses to notice such changes without requiring them to mount strong resistance. The professional responsibility is therefore asymmetrical: the nurse's greater control over the interaction generates a greater obligation to remain responsive to signs that the ethically relevant conditions have changed.

The relationship among these principles is represented in **Figure 1**.

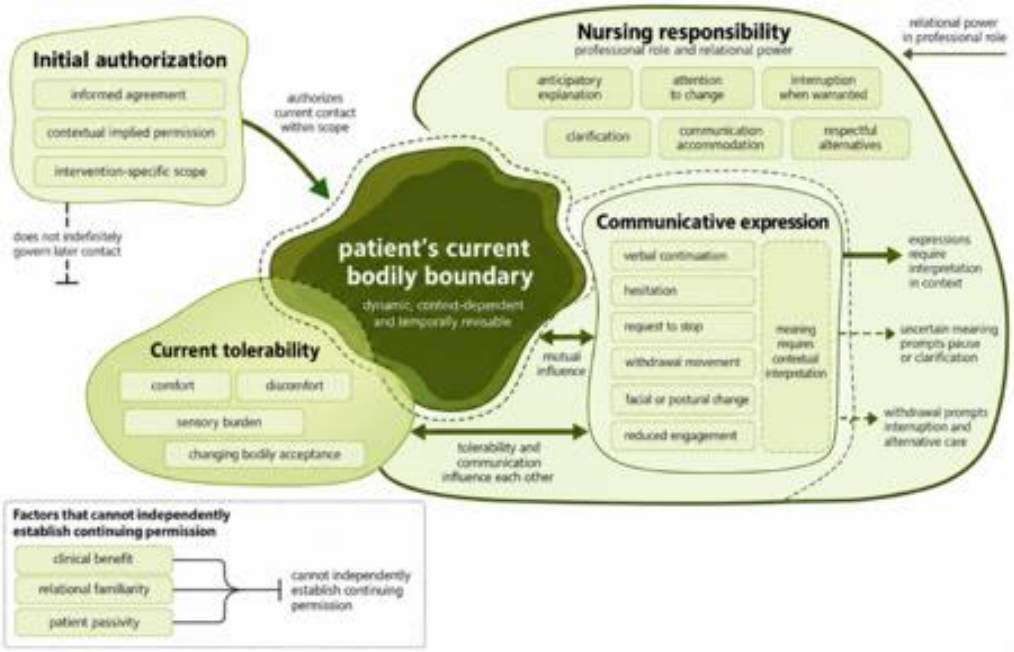


Figure 1. Continuing permission across changing bodily tolerance and communicative clarity during therapeutic touch

The problem of changing permission

The most difficult ethical problem arises after touch has already begun. Consent discussions often focus on the moment preceding an intervention, but serious illness creates conditions in which preferences may change rapidly.

Palliative-care professionals have reported precisely this difficulty in relation to information preferences: patients may initially request information and later reject it, leaving clinicians uncertain about how strongly to preserve the earlier preference and how to interpret the newer one [18]. Information disclosure is different from therapeutic touch, yet the temporal lesson is transferable. A preference expressed at one point in serious illness cannot automatically determine what should happen later when the person's experience, priorities or tolerance have changed.

Touch intensifies the temporal problem because the intervention is embodied and continuous. Agreement may be genuine at initiation and still cease to authorize continuation. A patient may initially welcome massage, hand-holding, comforting pressure or assistance with repositioning, then become fatigued, overstimulated, painful or emotionally uncomfortable. The ethical significance lies in the change itself. Continuing consent becomes relevant exactly because no deception or error need have occurred at the beginning. The nurse and patient may both have reasonably understood the intervention as acceptable, yet that judgment can become obsolete as the episode unfolds.

Research on refusals of personal care among people with advanced dementia illustrates how complex these transitions can become when verbal communication is limited. Family carers and care-home staff describe using timing, simplification, reassurance, adaptation, pausing and returning later when assistance is refused [19]. Such strategies cannot be imported wholesale into serious-illness touch practice, and dementia-related refusals should not be treated as equivalent to decisions made by adults with intact decision-making capacity. The evidence is nevertheless important because it demonstrates that resistance is an interactional event requiring interpretation and response rather than merely an obstacle to task completion.

Quantitative work in advanced dementia also suggests that refusal is context-sensitive and cannot be reduced to a single caregiver characteristic or educational deficit [20]. Some refusal patterns are associated with patient-level clinical or behavioural features, whereas caregiver training status alone does not explain the phenomenon. For the present analysis, the significance is conceptual: when a person resists touch, the nurse should avoid assuming that one standardized explanation accounts for the response. Pain, fear, misunderstanding, sensory sensitivity, fatigue, unfamiliarity, embarrassment and desire for control may produce superficially similar behaviors but require different responses.

Consent becomes even more difficult when communication is partly non-verbal. Dementia-care staff describe a “gray area” in which they rely on speech, facial expression, body language and knowledge of the person when attempting to understand whether care remains acceptable [21]. Such relational knowledge may improve sensitivity, but it also produces a risk of interpretive overconfidence. A nurse who knows a patient well may become better able to recognize subtle withdrawal; the same familiarity can also encourage the belief that the nurse already knows what the patient means. Relational knowledge therefore improves the evidence available for interpretation without eliminating the need for caution.

For touch-based care, the crucial distinction is between a signal that requires a response and a signal that conclusively determines meaning. Pulling away, stiffening, turning the head, becoming suddenly quiet or refusing to engage may justify interruption and clarification. None can be assigned a universal semantic value independent of context. A movement away may reflect pain, surprise or withdrawal. Silence may reflect fatigue, fear, trust or inability to respond. Conversely, lack of resistance may occur because the patient lacks strength, does not understand that refusal is possible or wishes to avoid disappointing the nurse. Continuing permission therefore cannot be inferred mechanically from either action or inaction.

Patient participation research reinforces this need for relational interpretation. Patients describe shared decision-making in nursing care as depending partly on whether they feel seen, understood and taken seriously by nurses [22]. People receiving home-based palliative care likewise describe participation as something navigated within relationships and major life circumstances, rather than as a uniform preference for maximal control over every decision [23]. This matters because an ethics of continuing consent should not demand constant active decision-making from patients who do not want it. The aim is to preserve the possibility of influence over bodily access, not to impose a cognitively burdensome consent ritual.

Dignity remains relevant when autonomy is impaired or difficult to express. Ethical analysis of care for persons with impaired autonomy emphasizes that human and identity-related dignity continue to place obligations on caregivers even where conventional autonomous choice is constrained [24]. Yet dignity cannot substitute for permission. A nurse cannot justify continued touch merely by believing that the intervention preserves dignity, just as an ambiguous patient response cannot be treated as a definitive refusal without considering context. The ethical task is to preserve both dimensions: respect the patient's current bodily signals while avoiding unsupported claims about what those signals conclusively mean.

The problem of changing permission can therefore be described through four recurring clinical situations. First, permission remains clear and tolerability appears unchanged. Second, the patient continues to cooperate but shows signs that contact may have become difficult to tolerate. Third, the patient communicates explicit or reasonably clear withdrawal. Fourth, the patient's response becomes ambiguous because communication, cognition, fatigue or distress makes interpretation uncertain. These are not validated clinical categories, and they should not be

converted into a scoring system. Their purpose is to show why a single earlier "yes" cannot resolve every later state.

Table 2 consolidates these distinctions by linking changing permission states to proportionate nursing responses. The responses are conceptual and evidence-informed rather than experimentally validated practice standards.

Table 2. Changing permission during therapeutic touch and proportionate nursing responses

Evolving situation during touch	What may be occurring	Ethically relevant uncertainty	Proportionate nursing response	What should not be inferred
Earlier permission remains congruent with present engagement	Contact continues to appear acceptable and the patient remains able to influence how it is delivered	Whether tolerance will remain stable as symptoms or fatigue change	Continue responsively while preserving an easy opportunity to modify or stop	Previous consent guarantees acceptance for the entire episode
Initial assent persists but tolerability becomes uncertain	The patient still appears cooperative while discomfort, tension, withdrawal or reduced engagement emerges	Whether behavior reflects ordinary symptom fluctuation, distress, sensory overload or changing willingness	Reduce or pause contact, orient the patient, clarify if feasible and adjust intensity, duration or modality	Cooperation proves that continued touch is wanted
Withdrawal is verbally or behaviorally clear enough to make continuation ethically doubtful	The patient requests stopping, moves decisively away, repeatedly resists or otherwise communicates non-continuation	Whether the underlying reason is pain, fear, preference, misunderstanding or another cause	Interrupt the touch, acknowledge the change, assess communication or symptom needs and offer acceptable alternatives where available	Identifying the precise cause is required before honoring withdrawal
Meaning is ambiguous because expression is limited or inconsistent	Communication barriers, fatigue, cognitive change or severe illness make the patient's current preference difficult to determine	Whether observed behavior reflects consent, refusal, distress or diminished ability to respond	Pause or slow the interaction, use communication accommodations, seek context from the patient and appropriate relational knowledge, and avoid unnecessary continuation while uncertainty remains	Silence, passivity, familiarity or clinician confidence constitutes permission
Clinically useful touch is no longer acceptable in its current form	The goal of care remains important but the mode of delivery conflicts with present bodily boundaries	Whether a modified or non-touch alternative can meet part of the same goal	Negotiate a less intrusive form, different timing, different intensity, another professional approach or a non-touch alternative where clinically feasible	Refusal of one touch intervention equals refusal of all care
Patient preference fluctuates across repeated encounters	A previously accepted intervention is wanted on some occasions and rejected on others	Whether clinicians will mistake historical preference for a standing authorization	Treat each new episode as informed by history but governed by present preference and tolerability	Consistency is required for the patient's preference to be legitimate

The central difficulty is therefore not that nurses lack a perfect method for decoding every response. Such a method is unlikely to exist. The more defensible ethical position is that uncertainty changes what continuation requires. When new behavior plausibly indicates altered tolerance or withdrawal, the burden of interpretation should not fall entirely on the patient. Nurses can interrupt, slow, clarify and adapt without first proving exactly why the response occurred. This is particularly important during serious illness, where exhaustion or dependence may make strong resistance difficult.

At the same time, the analysis should not convert every movement, silence or expression into a withdrawal event. Such an approach would undermine therapeutic relationships and could make ordinary care unnecessarily cumbersome. The ethical objective is responsiveness, not surveillance. What distinguishes continuing permission from a one-time model of consent is therefore the continuing revisability of bodily access. The next section develops that proposition into the touch-specific conceptual framework, including the distinction between permission and tolerability, the role of interruption, and the conditions under which respectful alternatives become ethically important.

Proposed conceptual framework

The Continuing Consent and Bodily-Boundary Framework begins from a temporal proposition: permission to touch is valid for the interaction to which it applies, but it does not become a standing entitlement to the patient's body. Decision-making models in other areas of healthcare increasingly recognize that preferences can be revisited as circumstances change [25]. Therapeutic touch requires the same temporal sensitivity because the intervention unfolds through bodily experience rather than ending at the moment of initial agreement. Previous acceptance remains relevant contextual information, but present willingness governs whether the same contact can ethically continue.

The framework therefore separates permission from tolerability. Permission concerns whether the nurse currently has an ethically defensible basis for initiating or continuing the contact. Tolerability concerns how the patient is presently experiencing that contact. They may coincide, but they need not. A patient can genuinely authorize an intervention and later find it painful, exhausting or intrusive. Conversely, a person may physically tolerate an action while preferring that it stop. This distinction prevents bodily endurance from becoming a substitute for choice and prevents clinicians from assuming that absence of overt resistance means continuing authorization.

A second proposition concerns the interpretation of change. Therapeutic relationships generate knowledge: nurses learn how particular patients usually speak, move, respond to discomfort and express uncertainty. Such knowledge can improve sensitivity to subtle changes. It cannot remove interpretive uncertainty. Non-verbal behavior should therefore function as information that may require action, rather than as a universally reliable code. Evidence from caring-touch research shows that bodily responses can communicate experience [2], while dementia-care research demonstrates how difficult it can be to determine consent from behavior alone [21]. The framework consequently treats withdrawal movements, tension, hesitation, silence or reduced engagement as possible reasons to slow, pause or clarify, without converting any single behavior into a validated consent rule.

A third proposition concerns interruption. In clinical culture, stopping an intervention can appear to signal failure, inefficiency or incomplete care. Within this framework, interruption has a different meaning. A proportionate pause can be an ethical component of good nursing when it restores the patient's opportunity to influence bodily access. Research on consent before nursing procedures emphasizes that patients require meaningful alternatives when permission is withheld [12], while refusal-management evidence shows that changing timing, simplifying interaction or returning later may enable care without treating resistance as something to defeat [19]. Interruption is therefore neither automatic abandonment nor evidence that touch was inappropriate from the outset. It is a mechanism through which continuing permission can be reassessed.

The fourth proposition is that communication accommodation belongs inside consent rather than after it. A patient whose speech is weak, delayed or inconsistent still requires a workable means of expressing continuation, uncertainty or withdrawal. Nurses may need to reduce conversational complexity, allow additional response time, use gestures or augmentative communication, involve an appropriate communication partner, or separate explanation from physical contact so the patient is not asked to process both simultaneously. Interactional research shows that the way nurses structure communication can affect whether readiness for action becomes observable [17]. Accommodation consequently changes the quality of the permission process itself.

The framework also distinguishes relational trust from relational entitlement. Longstanding trust can make touch easier to negotiate and may allow subtle preferences to be recognized. Relational autonomy similarly acknowledges that agency is supported through social relationships rather than exercised in isolation [10]. Yet familiarity cannot ethically expand the nurse's authority beyond the patient's present boundary. A patient may welcome comforting touch from a familiar nurse on one occasion and refuse it later. The relationship helps interpret preference; it does not replace preference.

Clinical benefit is constrained in the same way. Shared decision-making scholarship shows that the intensity and form of participation appropriate to healthcare decisions varies with the nature of the decision and context [26]. Touch-based nursing therefore does not require identical consent procedures for every action. Brief routine contact, massage, intimate assistance, positioning and prolonged manual therapies differ in invasiveness, duration, predictability and opportunity for withdrawal. The framework calls for proportionality: the greater the bodily exposure, duration, uncertainty or possibility of distress, the stronger the need for explicit orientation and continuing attention to response.

When withdrawal becomes sufficiently clear, the ethical presumption shifts toward interruption. The nurse does not need to establish the precise psychological or clinical cause before respecting a request to stop. Assessment may follow after contact has ceased. Where the care goal remains important, alternatives may include later timing, reduced duration, a different technique, verbal reassurance without touch, patient-directed positioning, another practitioner or another clinically appropriate modality. Refusal of one form of touch should therefore not be interpreted automatically as rejection of care as a whole.

The framework is intentionally non-algorithmic. It supplies no behavioral score, mandatory reassessment interval or universal verbal script. Such precision would exceed the supporting evidence and risk creating false confidence. Its contribution is conceptual: it identifies which distinctions must remain visible when nurses reason about bodily contact during serious illness. Initial authorization, current tolerability, communicative interpretation, interruption

and alternatives form a connected process, but none can substitute for the others. Continuing consent is thus best understood as the preservation of a patient's practical ability to revise access to their body while care is occurring.

Results and Discussion

The framework reframes therapeutic touch as a practice whose ethical quality depends partly on temporal responsiveness. This position accommodates the substantial nursing literature that regards touch as relationally valuable while addressing evidence that bodily contact can also become uncomfortable or dignity-threatening. It therefore avoids two extremes: treating therapeutic touch as presumptively benign because it is caring, or treating physical contact as ethically suspect unless repeatedly formalized through explicit verbal consent.

For nursing practice, the principal implication is attentiveness to change. Initial agreement remains important, but the clinical encounter should retain opportunities for modification or withdrawal. A nurse may accomplish this through ordinary relational practices: explaining what will happen, allowing the patient to guide intensity or duration, noticing changed engagement, pausing when a response becomes uncertain and making alternatives visible. These practices need not become a repetitive consent ritual. Their purpose is to prevent the workflow of care from becoming more authoritative than the patient's current bodily experience.

Education is therefore relevant, particularly where nurses are expected to communicate with people experiencing severe illness, cognitive burden or limited speech. Existing serious-illness communication education uses heterogeneous modalities, and evidence for durable changes in clinician behavior and patient outcomes remains incomplete [27]. An educational intervention based on this framework should consequently not be presented as already established. Future curricula could nevertheless test whether nurses can learn to distinguish initial permission from continuing tolerability, recognize ambiguous withdrawal without overinterpreting it, and use interruption as a legitimate component of care.

Cultural considerations require similar caution. Expectations regarding touch vary across families, communities, genders, generations and care settings, and cultural familiarity may help nurses avoid preventable discomfort. Yet culture cannot determine an individual's preference in advance. The dignity literature demonstrates the importance of control and preparation around bodily contact [6], while work on professional boundaries emphasizes the asymmetrical power carried by healthcare relationships [13]. Cultural sensitivity should therefore generate better questions and more flexible care, rather than assumptions that a member of a particular group either welcomes or rejects touch.

The framework also has implications for patients who prefer relatively little active participation. Shared decision-making evidence suggests that participation is not experienced identically by all patients [22]. A patient may explicitly prefer the nurse to take the lead while still expecting bodily withdrawal to be respected. Continuing consent therefore does not require maximizing the number of decisions imposed on the patient. It requires maintaining meaningful control over the specific boundary at issue. A low preference for deliberation is compatible with a strong right to stop unwanted contact.

Important limitations remain. Much of the strongest touch-specific evidence comes from intensive care, integrative oncology or symptom-focused interventions rather than from studies explicitly examining withdrawal of permission during palliative therapeutic touch. Evidence concerning non-verbal refusal is especially dependent on dementia and personal-care research. Those sources illuminate mechanisms of ambiguity, vulnerability and interpretation, but they cannot establish that the same behaviors carry identical meanings among adults with serious illness who retain decision-making capacity.

The proposed distinctions also require empirical testing. Patient interviews should examine whether people themselves distinguish between agreeing to touch and continuing to tolerate it, how they communicate when a previously acceptable intervention becomes unwanted, and which nursing responses preserve control without increasing burden. Observational studies could explore how verbal and non-verbal expressions unfold within real touch episodes, while culturally diverse qualitative work could test whether the framework's assumptions travel across settings. Any future instrument should be approached cautiously: a numerical measure of “continuing consent” could obscure precisely the context dependence that the framework is designed to preserve.

Legal scope is another limitation. The framework is an ethical and nursing-conceptual analysis, not a substitute for jurisdiction-specific consent law, mental-capacity assessment or emergency-care doctrine. Situations involving immediate threats to life, legally authorized substitute decision-making or involuntary treatment raise additional questions that are outside its ordinary application. Its primary domain is non-emergency touch-based nursing in which there remains practical opportunity to pause, clarify, adapt or provide alternatives.

Despite these boundaries, the framework identifies a clinically important conceptual gap. Nursing has strong languages for caring touch, autonomy, dignity and person-centred communication, yet these bodies of scholarship are often considered separately. Bringing them together reveals that the morally relevant question is not simply whether touch began appropriately. The continuing question is whether bodily access remains justified as the patient's experience changes. That question is especially important in serious illness because dependency, fatigue and communication difficulty may reduce the patient's ability to withdraw in forceful or conventional ways.

Conclusion

Therapeutic touch can remain a meaningful and humane component of integrative nursing during serious illness, but its caring purpose does not create permanent permission. Bodily access is ethically contingent on the patient's present situation and must remain revisable after contact begins.

The Continuing Consent and Bodily-Boundary Framework distinguishes initial authorization from continuing tolerability and treats changing verbal or non-verbal responses as clinically meaningful without assigning them automatic or universal interpretations. Its central practical implication is proportional responsiveness: when tolerance or willingness becomes uncertain, nurses should preserve opportunities to pause, clarify, accommodate communication and consider acceptable alternatives.

This account does not turn every episode of touch into a formal consent procedure, nor does it establish a validated clinical algorithm. It positions therapeutic touch as an ongoing relational negotiation in which trust, clinical purpose and familiarity matter, while the patient's present bodily boundary remains decisive. Empirical work is now needed to test how these distinctions are experienced by patients and operationalized by nurses across palliative, integrative and serious-illness settings.

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