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Surgical consent and the importance of a substitute decision-maker: A case study

At law, all individuals are presumed to have the legal capacity to provide consent or refusal of treatment unless there are clinical indications of cognitive impairment. Once concerns are raised regarding the ability of an individual to provide valid consent for a surgical procedure, the use of a substitute decision-maker may be necessary. In this paper, we present an analysis of a clinical case study to illustrate the principles of valid consent. As part of the analysis, we discuss the issues relating to obtaining valid consent for an operative surgical procedure from an elderly client with obvious cognitive impairment. We also explore the role of a substitute decision-maker to obtain the requisite valid consent.

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The legal doctrine of informed consent is the basis for ethical surgical treatment. It acknowledges that patients are autonomous, with the basic human right to make decisions regarding the treatment they receive[1].

In this paper we highlight the explicit role of informed consent and the use of a substitute decision-maker for individuals with impaired legal capacity using a case study involving an elderly couple who both have impaired cognition. In this case study, Elsie requires surgical repair of a fractured humerus but is unable to provide informed consent due to decreased cognition. Her husband, Bert, also has impaired cognition and the nursing staff must seek a substitute decision-maker to provide an informed consent for Elsie.

The role of the perioperative nurse in patient advocacy

A nurse acts as the patient's advocate and nowhere is this more applicable than the perioperative setting where patients are at their most vulnerable[1,2]. Most nurses working in the perioperative area have a basic understanding of the nuances relating to informed consent. The importance of obtaining an informed consent has been highlighted in various legal cases and articles written for nurses and medical officers over recent years[1,2], with this information used by organisations and facilities to guide process and protocols around obtaining an informed consent from a patient[1].

The basic principles of informed consent have been well established over time and are underpinned by the acceptance that every adult with legal capacity has a right to decide what shall be done with their own body. Any health care provider who performs a procedure without the patient's consent commits assault and is liable for damages which can be claimed against them[3]. In obtaining an informed consent from a patient, the medical officer must disclose details of the proposed treatment, any alternative treatments available and the risks and benefits of all treatment options, thus allowing the patient to consider all the information given and make an informed decision[1]. Nurses who step outside their role and obtain a consent from a patient for a procedure in place of the medical

officer, may face increased liability for their actions[4].

Statutory law, professional guidelines, codes of ethics and the common law all apply to the issue of informed consent for both medical and nursing staff[4]. In addition, a health care provider may face disciplinary action from their registering authority as a result of their actions if they are found to be negligent in obtaining an informed consent for a procedure[5].

Consent given by a patient for any procedure can be verbal or written, and implied or explicit[5]. The consent given for a surgical procedure is, by its nature, very precise about the procedure to be performed, and it must be in writing, providing the physical proof that informed consent has been obtained from the patient[4]. Explicit in this process is the expectation that a discussion has occurred, either with the patient or their legal guardian, about what the procedure entails, the benefits, risks and alternatives[6].

There are five elements within the doctrine of informed consent[7]:

1. Competence: does the patient have legal capacity to understand the information presented to them by the medical officer and to be able to make a decision regarding treatment?
2. Disclosure: has the medical officer discussed and disclosed all relevant risks and benefits of the proposed procedure to the patient in terms which are easily understood?
3. Understanding: does the patient understand what the proposed procedure entails?
4. Voluntariness: does the patient agree to the proposed procedure voluntarily and without duress from health care staff or family members?
5. Consent: has the patient consented to undergo the proposed procedure after considering all information provided to them?

The purpose of obtaining an informed consent from a patient is for the attending medical officer to provide the patient with all the relevant information relating to the intended procedure and then allow the patient to make the decision to either undergo the procedure or to refuse it[8]. The mere giving of a printed booklet on the condition or disease is not sufficient, and the medical officer must discuss all relevant information with the patient in unambiguous language, allowing them to ask questions, if they choose[8].

Whilst procedures can be undertaken without consent in emergency situations[9], patients who claim that they have not given consent for a procedure, may institute legal charges against medical and nursing staff for negligence, assault and battery[9]. In Rogers v Whitaker[10], the court found that it remained the medical officer's responsibility to inform their patient about all material risks of the intended procedure, and this responsibility remains non-delegable and absolute[10]. In this case, the patient had been almost blind in her right eye for over 40 years due to a childhood accident. She consulted the ophthalmic surgeon and was told that an operative procedure would improve both the eye's appearance and would also probably improve the sight in it. The surgeon failed to disclose to the patient the risk of her developing a condition known as 'sympathetic opthalmia', which she developed post-procedure and which resulted in her losing all sight in her left, previously unaffected, eye[10]. As the procedure had not restored the sight in her right eye, she was almost totally blind as a result and sued the surgeon for negligence based on his failure to warn her of the risk of developing sympathetic opthalmia. The High Court ruled in favor of the patient, stating that medical officers were required to disclose all material facts that the patient would attach significance to and would form part of their decision-making process[10].

The perioperative nurse's scope of practice

One of the responsibilities of the perioperative nurse is to ascertain that the consent form has been completed and signed by the patient, but their responsibility does not end there. They also need to make sure that the patient has understood the explanation given by the surgeon and can articulate it to the perioperative nurse on request[11]. The perioperative nurse may ask the patient, using open-ended questions, to repeat their understanding of the procedure in their own words, and address any discrepancies with the operating medical officer. It remains the responsibility of the designated perioperative nurse to check all patient documentation prior to the patient entering the perioperative area for a surgical procedure and to communicate any discrepancies detected to the surgeon without delay[2].

Nurses work within their designated scope of practice which includes all the activities that nurses perform within their daily activities in a health care setting and all activities they are educated and authorised to perform[12]. Nursing scope of practice and conduct are guided by state and national legislation and common law, and nurses must also work in compliance with facility policies and procedures, remaining accountable for their actions to their employer. Common law precedents, particularly those dealing with negligence, impact on nursing practice within the perioperative setting[6]. Negligence is a three-part civil wrong, or tort,

involving a clearly defined duty of care owed by one person to another, breach of that duty and, as a result of that breach, the suffering of damage by the person to whom the duty is owed.

The Australian Nursing and Midwifery Council (ANMC) provide a national framework for decision-making for nurses[13]. Contained within these principles is the Code of Professional Conduct for Nurses in Australia which is supported by the Code of Ethics for Nurses in Australia[14].

The ANMC Standards are the means of assessing eligibility for registration and are the core measurement of performance for Registered Nurses in Australia. These standards include professional and ethical practice, critical thinking and analysis, provision of appropriate and patient-centred care, collaborative and therapeutic practice and the evaluation of care provided[14]. Australian nurses are responsible for ensuring their standard of practice conforms to the identified professional and wider community standards to provide safe, effective and patient-focused care.

The Australian College of Perioperative Nurses (ACORN) uses a framework where the ANMC Code of Ethics and Code of Professional Conduct is combined with the ANMC practice standards to define accountability for perioperative nurses[15]. This framework incorporates seven principles which outline accountability for practice. Principal 1 is particularly relevant to informed patient consent and discusses the need for perioperative nurses to familiarise themselves with and practise under relevant state and national legislation and best practice guidelines.

Acts and statutes

The Civil Liability Act[16] identifies that a professional does not breach the duty arising from the provision of a professional service if the professional acted in accordance with the highest professional standard, ethics and peer opinion; with reasonable care, knowledge and skill; and in accordance with recent research[16]. In Australia, legislation guides decisions made by health practitioners about the provision of health care to adults without the legal capacity to make such decisions for themselves. The Powers of Attorney Act 1998 (Queensland)[17] defines, by order of priority, who may make decisions for an adult with impaired capacity as a 'statutory health attorney'. Legislation in other Australian states has a similar definition. The statutory health attorney is deemed to be the first person within this listing who is 'readily available and culturally appropriate' to make the required decision[17].

In order of priority, this list identifies:

1. a spouse of the adult if the relationship between the adult and spouse is close and continuing
2. a person who is 18 years or more and who has the care of the adult and is not a paid carer for the adult
3. A person who is 18 years or more and who is a close friend or relation of the adult and is not a paid carer for the adult
4. the adult guardian.

A spouse will include de facto partners of either sex[17].

The process of obtaining an informed consent often begins long before the arrival of the patient in the perioperative suite. Many situations may arise which might call into question the patient's ability to make decisions about their proposed treatment, these include patients under stress and those with known mental illness or organic brain disease. Nurses who have performed their assessment of the patient can provide essential information to medical officers regarding a patient's ability to make decisions regarding the giving or withholding of consent[18].

Exemplar case study

In this article, we examine a case study, involving an elderly woman who was unable to provide informed consent for her operative procedure, to illustrate the elements of consent. As her substitute decision-maker, her husband provided verbal consent and signed the consent form, but there were doubts raised by nursing staff as to his capacity to provide an informed consent on her behalf.

Elsie, a 69-year-old female who lived with her 70-year-old husband, Bert, was brought into hospital via ambulance following a fall at home. Following assessment in the Emergency Department, x-rays revealed a fractured right humerus and Elsie was admitted to a ward before being transferred to theatre for insertion of a pin and plate to repair the fracture. During the admission process, nursing staff identified that Elsie had cognitive degeneration with extreme short-term memory loss. Bert stated that she had been like this for the past year and that he looked after her by helping her wash and dress but she could still feed herself and go to the toilet alone. Bert identified that he had suffered a small stroke three years before and sometimes had 'episodes' where he fainted and could not remember where he was but had not seen his GP about the episodes. Bert also told staff that he frequently forgot how to start the car and could not always find his way home from the shops.

Bert was present when the orthopaedic surgeon visited Elsie and explained the procedure to them both, and Bert signed the consent form for Elsie's operation as her next of kin. The anaesthetic nurse arrived

in the ward later that morning to transfer Elsie to the operating suite and spent time with both Elsie and Bert. During her conversations with them, she had concerns about Bert's ability to understand the proposed operative procedure and to legally provide informed consent for Elsie's procedure. The nurse contacted the surgeon, informed him of her concerns and was told that as the consent form had been signed that was sufficient and to bring Elsie to theatre as she was holding up the list.

The nurse transferred Elsie to theatre and informed the Nurse Unit Manager (NUM) and the scrub nurse of her concerns about the validity of the consent. Both nurses felt pressured by the surgeon to accept the consent as valid but the NUM discussed her concerns with the surgeon and the surgery was postponed until she could explore the issue further. The NUM met with Bert and formed the opinion that he did not appear to fully understand the operative consent process. She contacted the Director of Nursing (DON) and discussed her concerns about the validity of the consent. The DON met with the surgeon and asked him to contact Bert and Elsie's General Practitioner (GP) to confirm if he had identified that Bert and Elsie had decreased legal capacity to make their own health care decisions. The GP confirmed that he had discussed his concerns with Bert and Elsie a number of times and was prepared to provide documentation of his evaluation that both Elsie and Bert had impaired capacity and so were unable to provide valid consent. This confirmation was received by the surgeon via fax within half an hour. In the interim, Bert and Elsie's neighbor, Wally, arrived at the hospital to visit Elsie. Wally stated he had lived next door to Bert and Elsie for over 20 years and for the past two years had dropped in every day to see how they were. He regularly helped them with their shopping, paid their bills and considered himself their unofficial son. He was asked and agreed to provide consent for Elsie's procedure in the role of statutory health attorney and Elsie's procedure was rescheduled.

This issue was included in the agenda for the next theatre staff meeting and the Director of Nursing (DON) was invited to attend and discuss the situation. The DON identified that Wally acted as Elsie's statutory health attorney and signed the consent form as such, acting in her best interests. The discussion included who could make health care decisions for others, the role of the Statutory Health Attorney, decisions they could make and those they were unable to make.

Discussion

Typically, for patients who are capable of making their own medical and surgical decisions, the aim of health care staff is to help them make an informed choice regarding available treatment options, including refusal of treatment. If a patient lacks the legal competence to make a decision regarding treatment, a substitute decision-maker must be sought[19]. It is therefore imperative that the person is assessed regarding their cognitive level in order to respect the autonomy of patients who are able to make their own decisions and to protect the rights of those with cognitive impairment. Operative consent obtained from a patient with impaired cognition is invalid and surgeons who do not obtain a valid consent from a substitute decision-maker will have proceeded without informed consent.

Obtaining an informed consent from an elderly patient is a complex process and the treating medical officer needs to be aware of their obligations whilst ensuring that the primary focus is good practice and concern for the patient, not a fear of litigation[3]. There should be sufficient time for full details and explanation of the procedure to be made in plain language to the patient, along with details about alternative treatments, risks and benefits[20]. The patient also needs to be given sufficient time to reflect, absorb and discuss the proposed procedure with other family members if desired. As discussed, sometimes a patient presenting for an operative procedure will exhibit indications of impaired capacity which have not been previously identified by either themselves or family members. In this case study, a substitute decision-maker was available and willing to take on the responsibility for the decision regarding Elsie's medical care – without the informed consent obtained from Wally, Elsie's surgical procedure could not have proceeded.

All members of the health care team have valuable information about the patient to share with the attending medical officer regarding the patient's preparedness and ability to provide informed consent. Perioperative nurses need to adhere not only to the organisation's policies and procedures regarding the consent process but also to the ANMC decision-making framework and codes of practice. Failure to do so may result in serious repercussions for the staff member from both the employer and registering body.

Conclusion

The importance of informed consent prior to an operative procedure is paramount. Perioperative nurses must be aware of their role and responsibilities when checking that a patient has signed a consent form prior to undergoing an operative procedure – they are responsible for ensuring the form has been signed and asking the patient to articulate their knowledge of the intended procedure in their own words. The non-delegable responsibility for providing necessary information and

advice to the patient remains the responsibility of the treating medical officer.

If the perioperative nurse is in doubt as to the understanding that the patient has regarding their procedure, they are obliged to discuss their concerns with the operating medical officer as soon as possible and prior to the patient entering the operating theatre. Failure to obtain the patient's consent for a procedure may result in civil charges for assault and battery and failure to disclose all relevant material risks regarding the procedure, may result in a civil charge of negligence[21].

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