

LES JEUNES ADOLESCENTS SIGNANT LEURS PROPRES FORMULAIRES DE CONSENTEMENT POUR UNE INTERVENTION CHIRURGICALE :

Un dilemme éthique-légale pour les infirmières et infirmiers périopératoires autorisés

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RÉSUMÉ

Les problèmes de nature éthique-légale, définis dans le présent document comme des situations qui peuvent engendrer des répercussions légales, qui présentent des raisons morales convaincantes pour et contre une action particulière et qui exigent la prise de décision¹, ne sont pas rares dans le domaine des soins de la santé. Lorsqu'un jeune adolescent (défini comme une personne à charge ou de moins de 18 ans) consent à une intervention chirurgicale, des répercussions légales peuvent s'ensuivre. Le cas d'une fugueuse de 14 ans qui a signé son propre formulaire de consentement pour une cholécystectomie est examiné. Le concept du consentement est discuté et lié à une étude de cas concrète. Les éléments d'un consentement valide et informé sont identifiés, examinés et liés à l'étude de cas. En appliquant le modèle MORAL pour la prise de décision éthique², les enjeux éthiques du cas sont étudiés. Les répercussions légales possibles sont traitées et une stratégie de gestion des risques (protocoles de politique et de documentation relatifs à la procédure de consentement) est suggérée et évaluée.

1. Canadian Nurses Association 2002, Code of Ethics for Registered Nurses, Canadian Nurses Association, Ottawa.

2. Guido, G.W. 2003, 'Legal and ethical issues', in P.S. Yoder-Wise (ed), *Leading and managing in nursing*, Mosby, St. Louis, pp. 49-73.

YOUNG TEENAGERS PROVIDING THEIR OWN SURGICAL CONSENTS:

An Ethical-Legal Dilemma For Perioperative Registered Nurses

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ABSTRACT

During the delivery of health care, ethical-legal problems are not uncommon and can be defined as situations that have potential legal consequences when equally compelling ethical reasons for and against a particular course of action are recognized and a decision must be made.¹ Ethical-legal repercussions may occur when obtaining surgical consent from a younger teenager (defined as dependant and/or under 18 years of age). An ethical-legal dilemma arising from the case of a 14-year-old, run away girl, who had signed her own surgical consent for a cholecystectomy is analyzed. The concept of *consent* is discussed and related to an actual case study. The elements of a valid informed consent are identified, discussed and related to the case study. Using the *MORAL model for ethical decision-making*² the ethical implications of this case are analysed. Possible legal repercussions are addressed and a risk management strategy (suggested policy and documentation protocols for the consent process) is proposed and evaluated.

CASE STUDY

Sara (pseudonym) is an experienced perioperative nurse working in Alberta, Canada. On the day of this case she was circulating for a general surgery room working with a general surgeon (Dr. B). Between cases Dr. B was called to the emergency department to assess a patient who had presented there. When he returned, 20 minutes later, to the theater he informed the staff that he needed to do an emergency laparoscopic cholecystectomy at the end of the scheduled surgical list. The nurses were told to prepare the room for an adult female patient.

Sara and the scrub nurse, Polly (pseudonym), prepared the room. Once Polly was scrubbed and counted into the case Sara went to the holding area to assess the patient and to bring her in for surgery. Sara found the patient, a 14 year-old girl, Dianne (pseudonym), lying on the stretcher. Families commonly accompany patients to the holding area but this girl was alone. Sara went through Dianne's chart and found the appropriate documentation including a hand-written history, vital signs that were within normal parameters, blood work and an ultrasound report that was positive for cholelithiasis. There was also a consent form for a "*laparoscopic cholecystectomy possible open*" that was signed by the 14-year-old patient and witnessed by Dr. B.

During the assessment interview Dianne was not making eye contact with Sara and her answers were concise and delivered in a monotone voice. She displayed no overt signs of distress and denied experiencing any pain or physical discomfort. She told Sara that she was having her gallbladder removed and accurately described the laparoscopic method and the reasons that might require conversion to the open method. She named the surgeon who was going to do the procedure and she said the problems would get worse if she did not have the procedure. She revealed that she had run away from home the previous week. Up until then she had been living with her mother in a city more than 1500 kilometers away in another province. She was apparently now staying with an 18-year-old sister. Sara wondered why Dianne had run away and suspected that a children's social worker should become involved.

Policy at the hospital in question dictated that surgical consents for minors required the signature of a parent or guardian or, in the case of emergency, by two physicians. Sara notified the OR manager and while they were discreetly discussing the consent issue Dr. B came to the holding area and asked loudly "What is the holdup? Bring in the patient." Sara told the surgeon about the consent policy and the issue at hand. He replied that he believed the patient could sign her own consent form because she clearly comprehended the procedure and its potential consequences. Sara suggested that since Dr. B had booked the case as a last minute "emergency" addition, the signature of two physicians would fulfill the hospital's policy criteria. Dr. B refused and began to become belligerent.

Sara asked to see a copy of the policy and was informed that it was not currently available in the OR as it was being rewritten. After further discussion between the OR manager and the surgeon, Sara was instructed to obtain consent over the phone from the mother. Sara stated that the surgeon should make this call, as he would be best able to explain the patient's medical situation and ensure the mother was giving an informed consent. The surgeon turned and left in a rage. The OR manager instructed Sara to call the mother and to explain that her daughter was going to have surgery. Sara reluctantly agreed to make the call if the OR manager would also listen to the telephone conversation and co-sign the documentation about the incident. Dianne was hesitant to divulge her mother's telephone number but eventually agreed to do so. The call was made in Dianne's presence and the medical and surgical situation was fully explained to the mother. The mother's response was "Do whatever you need to do". The entire incident was documented and signed by both Sara and her manager.

Dianne claimed, when asked, to have no further questions about the surgery. Sara transported Dianne into the OR where the procedure was completed with no complications. Sara was very uncomfortable with the situation. She was the mother of three teenage children and would have likely initiated a formal inquiry if one of her children had undergone a surgery without her consent. Sara thought about all the possible

TEENAGERS PROVIDING SURGICAL CONSENT (cont.)

complications that could occur during this patient's surgical experience and was very skeptical as to whether or not a court would find the mother's telephone consent to be legal. Sara meticulously and comprehensively documented the details of the case on the official operative detail and, later that evening, in her personal journal.

VALID INFORMED CONSENT

It is illegal for one person to touch another without that person's consent. Healthcare workers are required to touch patients in order to carry out their work. Consent from patients can be implied, verbal/oral, or written.³ Patients imply their consent through certain behaviours – holding out an arm to have their blood pressure, taken for example. However, during this process, the onus is on the health care worker to ensure the patient understands what he/she is consenting to and why. A patient can give verbal or oral consent after a procedure has been explained – agreeing to have a PAP smear is an example of oral consent. A written consent is more tangible and deemed to be more legally useful than an implied or oral consent.³ Informed consent is a process and signing the consent form is documentation of the process.^{4,5}

For informed consent to be valid in Canada the following criteria must be met: ^{5,6,7,8,9}

The patient must be legally competent to consent to the proposed treatment;

The patient must possess the mental capacity to authorize the proposed care;

The patient must receive a proper disclosure of information about the procedure from the practitioner proposing the treatment;

The authorization should be specific to the proposed treatment;

The treatment must be legal;

The patient should have opportunity to ask questions about the proposed treatment and to receive understandable answers;

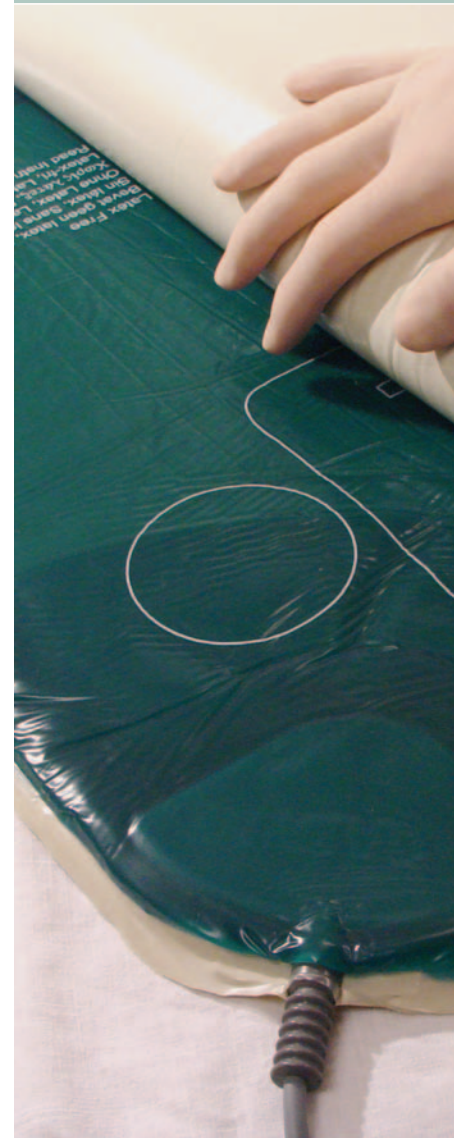
The consent must be genuine, voluntary, and obtained free from undue influence and coercion; and

The consent should be obtained free from misrepresentation of material information.

The patient must be legally competent to consent to the proposed treatment. In Canada the age of consent is not the age of majority.^{5,6} (Age of majority is the age where a person is legally recognized to be an adult and has the rights and responsibilities of an adult. In some provinces, including Alberta, the age is 18 years. In other provinces the age is 19 years.) Canadian common law recognizes the *rule of seven*. This rule says children under seven years of age are totally dependent on caregivers. Children seven to fourteen years are presumed capable of taking on some responsibility for their own actions and fourteen to twenty-one are responsible individuals accountable for their own actions. Canada also acknowledges the *mature minor rule* where it is believed that a minor is capable of understanding the nature and consequences of their decisions.⁶ If, however, this is challenged the law determines, in a case-by-case fashion, whether a child is capable of understanding the nature and consequences of the treatment or procedure.

Putting this information into the context of the case study it would seem that Dianne is legally competent to sign her own consent. However one would have to question if she was in fact capable of understanding the nature and consequences of having a cholecystectomy under a general anaesthetic. Was the surgeon able to assess her level of competence in the 20 minutes he saw her in the emergency department? Did Dianne's surgical and general life experiences allow her to fully understand the impact of the surgery? If there had been an adverse event during the procedure it is possible that legal litigation could have resulted if family and/or a legally appointed guardian pursued it. This is an example where the *rule of seven* and the *mature minor rule* might be interpreted differently by various professionals. There was no documentation on Dianne's chart to support the finding that she was thought to be legally competent and therefore able to sign the consent.

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The patient must possess the mental capacity to authorize the proposed care. This refers to the intellectual ability to reason – the ability to make a choice. It is presumed that all patients are mentally capable until found otherwise. Severe pain that compromises the ability to think, excessive consumption of drugs or alcohol, or a diagnosed mental disability are examples of criteria that could make a patient incapable of signing their own consent.⁶

From the facts that were disclosed in the case study there seems to be no reason to think that Dianne was mentally incapable of signing the surgical consent. However, it could be questioned as to whether or not she had the linguistic ability to comprehend what she was being told about the expected surgical experience. Did the surgeon explain the procedure and postoperative expectations in language that a 14 year old could easily comprehend and internalize? There was no documentation, other than the signed consent form, explaining how this particular process was carried out.

The patient must receive a proper disclosure of information about the procedure from the practitioner proposing the treatment. This is the most important criterion for a valid, informed consent and it means that a person must be given sufficient information, in understandable language, to make an informed decision. It is based on the 1980 Supreme Court of Canada case of Reibl v. Hughes, which found that proper disclosure describes

...what the average prudent person, the reasonable person in the patient's particular position, would agree to or not agree to, if all material and special risks of going ahead with the surgery or forgoing it were made known to him.^{5,6}

This information is to include the proposed procedure's nature and purpose; the risks and benefits; alternatives; impact on lifestyle; economic impact; who will perform the procedure and what their experience is; and consequences of refusing the procedure.^{5,6}

It would appear that Dianne had some knowledge of the cholecystectomy, as she was able to repeat her basic knowledge to Sara. But did she have full knowledge of the potential risks?⁸ The onus is on the surgeon to provide this information to the patient and to evaluate the level of understanding. Sara did not assess this but should have.⁷ The chart had no record of what Dianne was told or what her true level of understanding was.

The authorization should be specific to the proposed treatment. The specific procedure and who will be doing it should be indicated on the written consent. The consent form that Dianne signed specified *laparoscopic cholecystectomy possible open* to be done by Dr. B. The word *open* is ambiguous and likely would be questioned if litigation were to arise. Perhaps the wording should have been more specific and read *laparoscopic cholecystectomy possible cholecystectomy by laparotomy*.⁶

The treatment must be legal. There is no question, that a cholecystectomy is a legal procedure in Canada.

The patient should have opportunity to ask questions about the proposed treatment and to receive understandable answers. Patients must have ample time to synthesize the information told to them. A 'rush job' between disclosure and the decision to undergo treatment is not tolerated in Canadian law.⁶ Patients must be given time to formulate questions and receive appropriate answers prior to consenting.

The conversation between Dianne and Dr. B was not witnessed nor was the content of the discussion documented. It is unknown if these criteria were met. Dianne was not willingly conversing with Sara in the holding area and she denied having any questions about the surgery when asked. It is unknown whether or not she had questions or if she just did not want to talk to anyone. What is known, though, is that a short period of time existed between the signing of the consent and the actual surgery.

The consent must be genuine, voluntary and obtained free of undue influence and coercion.

This means the consent must be given voluntarily. There was no reason to believe that Sara did not give voluntary consent. However, it is known that patients trust and respect healthcare providers and may sign a consent because they fully trust the surgeon who is suggesting the surgical procedure.

The consent should be obtained free from misrepresentation of material information. This suggests that whomever obtains the consent (the practitioner who is going to perform the procedure) must not knowingly leave out details about the procedure or present them in a misleading fashion.⁶

In the case study involving Dianne there was no documentation or witness to the consent process. Therefore, there is no way of knowing if these criteria were met.

MORAL MODEL FOR ETHICAL DECISION MAKING

Nurses contend with ethical situations on a daily basis. The Canadian Nurses Association recognizes this and has provided all nurses with a Code of Ethics to guide them during these situations.¹ There are several models for ethical decision-making in nursing practice.^{2,10,11} The *MORAL model for ethical decision making* is perhaps the easiest model for nurses to remember as each letter of the acronym represents a step in the decision-making process.²

M - Massage the dilemma. Identify and define the issues and consider the options of the major people affected. In this case study Dianne has a diagnosis of cholecystitis. She is in no apparent physical distress. Cholecystitis does not usually require emergency surgery. For reasons unknown to the staff of the surgical suite, she has recently run away from her home. Dianne has a right to confidentiality.^{2,12,17} The reason she ran away is unknown. Therefore should the mother have been included in the consent? Should Family and Children's Services have been involved? If so, the mature minor rule may not apply. In Alberta this right is lost if the patient is subject to children's welfare

legislation. (Note: Each province has its own legislation concerning this issue.⁶)

Dr. B. is a skilled and regarded surgeon who believed Dianne needed immediate surgical treatment. Emergency surgery is done to prevent serious injury or to preserve life.¹³ Sara understood she was legally and professionally responsible and accountable for her actions. She believed that the consent process had not been completed and, as a patient advocate, she believed the patient's best interests were not being addressed. An option to suite all stakeholders (patient, family, perioperative nurses, surgeon, surgical assistant, anaesthetist, OR manager(s) and administrator(s), and any other person who would be directly affected by or involved in this patient's surgical experience) would be to delaying the surgery until the consent process was thoroughly reviewed.

O - Outline the options. Options, in this case, include performing the surgery immediately or delaying it. It would seem that delaying the surgery until the consent process was complete could have been a viable option so long as Dianne was not in immediate danger from the delay.

R - Resolve the dilemma by applying the principles of ethics to the identified issues and options. Principles of ethics include: autonomy (personal freedom); beneficence (to do good); nonmaleficence (to do no harm); veracity (complete truth); justice (equal and fair treatment); paternalism (assisting persons to make decisions when they do not have sufficient data or expertise); fidelity (keeping promises and commitments); and respect for others (the highest principle, incorporating all of the other principles).² These principles should be addressed from the perspective of each stakeholder.

A - Act by implementing the chosen option. In Dianne's case, it may mean delaying the surgery.

L - Look back and evaluate the process. Was the process successful or should it be modified in future?

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The process of ethical decision-making is not simple. It requires the cooperation of all stakeholders.

POSSIBLE LEGAL REPERCUSSIONS

Touching another person's body without their consent is illegal and can result in civil liability or criminal charges such as battery or trespass. The legality of Diane's consent is debatable and as a result one could question if the surgical team had legal permission to touch her body. Had there been an adverse event during her surgical experience the family and/or an officially appointed guardian could choose to legally pursue these questions in court.

Malpractice is the term used when a skilled and educated professional fails to act in a reasonable manner.^{2,10} A judge determines if the action was reasonable by evaluating how other professionals, with the same level of education and skills, would perform in the same situation. Physicians and nurses are professionals governed by their respective professional bodies and are all accountable, responsible, and liable for their actions.^{1,7,12} Many consent forms contain a clause giving the surgeon permission to alter the planned surgery should an unforeseen operable circumstance arise intra-operatively. However the surgeon who knowingly operates, beyond what has been consented to (without justification) and the nurses who knowingly participate in the procedure are equally liable.³

The hospital employing the nurses in this case could also found vicariously liable.^{13,16} Under Canadian law, employers have a responsibility to monitor and control their employees conduct.^{5,16} Hospitals have a duty to their patients to provide competent nurses.

Risk Management Strategy and Potential Evaluation

Risk management is a process that identifies, analyses, and treats potential hazards, such as the risk of injury, loss, and malpractice in the workplace.^{2,14} A risk management program should include the:

- identification and prioritization of risk areas;
- establishment of practice criteria collected from measurable data;

- implementation of practice strategies; and
- evaluation of the risk management program.¹⁴

These elements can be applied, as follows, to the case presented in this article:

The primary risk area is allowing young teenagers to sign their own surgical consents without documenting the essential elements of the consent process.^{3,11,14} A hospital's priority is to provide evidence of the care given to patients. Complete documentation contributes to such evidence.

Establish a policy that clearly defines the consent process, meets legal criteria and includes age-specific provisions. The policy should outline each step of the consent process and how it should be documented.⁸ This would provide a framework to ensure that the required elements of the consent process had been legally met.⁵ The policy should be made available to all health care providers at all times.

Implement the policy. This may include denying practice privileges to those individuals who do not comply with the written recommendations.

Re-evaluate, on a regular basis, to ensure that the policy remains consistent with current laws. Evaluate if the policy has, in fact, prevented the risk of malpractice for the professionals involved and the risk of vicarious liability for the employing institution. Evaluations should be written, retained, and readily accessible so they may be referred to for legal or quality assurance purposes.¹⁵

CONCLUSION

Ethical-legal dilemmas can arise when obtaining valid informed consents from young teenagers. The case of a 14-year-old run-away girl (Dianne) who had signed her own surgical consent for a cholecystectomy has been presented and analyzed. The elements for a legal informed consent were outlined and related to Dianne's case. Her consent was assessed for validity. Using the MORAL model for ethical decision-making the ethical implications of this case study were briefly analyzed. Possible legal repercussions were also addressed. A risk management strategy (suggested policy and

documentation protocols for the consent process) was proposed and an evaluation method briefly discussed. Ethical-legal problems are not uncommon in the delivery of healthcare and they need to be identified and prudently managed in order to prevent litigation.

IN SUMMARY:

Assessing the consent of a minor is an ethical-legal dilemma that often faces perioperative registered nurses.

Perioperative registered nurses have professional obligations to:

- Protect patients;
- Uphold professional standards; and
- Protect self and employers from liability.

To fulfill these obligations perioperative registered nurses must be aware of:

- Frameworks for ethical-legal decision-making;
- Criteria for informed consent by a minor in their own jurisdictions;
- Roles and responsibilities for obtaining informed consent; and
- Their own hospital's policy and procedures.

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