Legal Briefs

GENE A. BLUMENREICH, JD
AANA General Counsel
Powers & Hall
Boston, Massachusetts

Informed consent

Key words: Informed consent, spousal consent, standard of care.

As I am writing this I have recently returned from the 1992 AANA Annual Meeting. For four successive years, one of the most popular features of the Annual Meeting is the "Issues and Answers" session moderated by John D. Calloway, a senior correspondent, public television station WTTW in Chicago. This year's program on "Clinical Ethics" concerned healthcare reform and, as usual, was provocative and interesting. During the intermission, I talked to a CRNA from Nebraska about some of the issues raised by the program. Our conversation turned to the subject of informed consent.

Informed consent is a fundamental right of any surgical patient. It is almost always found in any draft of a patient's fundamental rights. It is good, it is absolute, and everyone agrees that no patient should be deprived of it. However, as the CRNA explained to me, even for so fundamental a right, there can remain questions of the application of that right in particular circumstances.

The fundamental principle of informed consent is relatively clear. Almost 80 years ago, Justice Cardozo, a well-respected jurist wrote, *"Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable for damages." Schloendorff u Society of New York Hospital,* 105 N.E. 92 (New York, 1914) overruled on other grounds, *Bing u Thunig,* 143 N.E. 2d 3 (New York, 1957).

Informed consent has been in the news lately. A form for informed consent prepared by a subsidiary of the AANA was favorably reviewed recently in a publication which discusses cases involving anesthesia and the law. The CRNA with whom I spoke well understood informed consent and its necessity in modern healthcare. Her concerns were practical. What happens, she asked, when the surgeon gets consent for a procedure without discussing with the patient the possibility that something may happen during the procedure which will require additional surgical intervention for which there may be additional risks?

Statute makes recovery of damages impossible

A recent case, while not answering these questions, illustrates some of the legal principles. In *Lounsbury u Capel* (191 Utah Adv. Rep. 40; July 17, 1992), the plaintiff sought to recover damages on the grounds that the surgeon had performed surgery on him without consent. The trial court ruled before the plaintiff offered any evidence that even if the plaintiff was able to prove all of the facts the plaintiff alleged, a Utah statute governing the failure to obtain informed consent made recovery impossible. Moreover, under Utah law, the consent of the plaintiff's wife constituted an absolute defense. Therefore, the trial court dismissed the case before any evidence had been offered. The plaintiff appealed to the Utah Court of Appeals which dis-

agreed with the trial court's determination and ordered the case to proceed to trial.

Because of the nature of the case, the Appeals Court accepts the plaintiff's version of events as the facts of the case. The plaintiff had injured his back. He was placed on a program of conservative care. Eventually his physician ordered a myelogram. The physician concluded that the plaintiff had a herniated disk and suggested that the plaintiff consider surgery to remove the disk material. The plaintiff had misgivings about surgery and requested a second opinion. He was referred to the defendant. The plaintiff testified that he had "apprehensions" about the defendant surgeon from the beginning and felt that the surgeon had prejudged that he should have surgery.

Despite his "apprehensions" the plaintiff scheduled a myelogram with the defendant. The plaintiff claimed, however, that on several occasions he advised the defendant surgeon and members of the defendant surgeon's staff that the plaintiff would *not* decide whether to have the surgery until after he had had an opportunity to see the new myelogram results and to discuss them with the surgeon. After the myelogram was performed, a nurse requested that the plaintiff sign a consent form but the patient refused. Later that afternoon a nurse anesthetist talked to the plaintiff about anesthesia for the proposed surgery. The anesthetist had a consent form for the anesthesia services, but again the plaintiff refused to sign the form because he wanted to talk to his doctor before he consented to surgery.

Spousal consent

The next morning the plaintiff received an injection, which apparently turned out to be a preoperative medication. The injection was the last thing the plaintiff remembered about the day of surgery. The plaintiff's wife arrived at the hospital and was given a stack of papers to sign. She testified that she felt intimidated and pressured. Assuming that her husband had talked to the surgeon and agreed to the surgery, she signed the consent forms. The surgery was performed, but the plaintiff has not fully recovered, and he claims that he continues to experience mental depression and psychological problems associated with the surgery and his continuing pain.

Although the Appellate Court is obligated to accept the evidence most favorable to the plaintiff, the surgeon claims that, in fact, the plaintiff called his wife and asked her to come to the hospital to sign papers on his behalf, that the plaintiff did not complain about the surgery during his stay in the hospital nor in the two years prior to the filing of the lawsuit.

It appears that there will be conflicting evidence to be presented at the trial ordered by the Appellate Court.

The Utah statute cited by the trial court was apparently designed to reduce litigation over whether proper informed consent was obtained. The statute provides that there is a presumption that what the healthcare provider did was authorized unless the patient can prove a number of different elements including:

- The patient had suffered personal injuries arising out of the healthcare rendered.
- The healthcare rendered carried with it a substantial and significant risk of causing the patient serious harm.
- The patient was not informed that there was a substantial and significant risk.
- A reasonably prudent person in the patient's position would not have consented to the healthcare if he or she had been fully informed as to all relevant facts.
- The unauthorized healthcare was the cause of personal injury suffered by the patient.

Burden of proof not established

In *Lounsbury u Capel,* the trial court determined that the plaintiff would not be able to establish that he suffered personal injuries arising out of the healthcare rendered nor would he be able to show that the unauthorized part of the healthcare was the cause of his injuries. The plaintiff's complaint was that he was no better because of the surgery; not that he was actually harmed by the surgery. Consequently, the trial court held that the plaintiff's claims had to be dismissed because the plaintiff could not establish his burden of proof under the statute.

The Utah statute is an attempt to further define some of the issues which the CRNA and I discussed at the Annual Meeting. How much information is required in order to have "informed consent?" If the information is not complete (and by necessity, it almost never will be since the patient cannot possibly have the background that the healthcare provider has), does missing information mean that there has been no consent? The Utah statute provides that there is a presumption running in favor of the healthcare provider. It attempts to avoid litigation over minor omissions. If the information is defective, it does not mean there was no consent. It simply means that there was no consent to the unauthorized portion of the surgery. For the plaintiff to prevail, the unauthorized portion of the surgery must cause the injury. Moreover, if a reasonable, prudent person in the patient's position would have

consented to the healthcare rendered when given the relevant facts, there can be no recovery.

The Appellate Court was faced with a dilemma. The legislature had passed a statute designed to reduce frivolous lawsuits based on defective consent. The one circumstance the legislature had apparently not considered was a case where the informed consent was not merely defective, it was nonexistent. The plaintiff attempted to get around the statute by arguing that he had a claim based not on the lack of informed consent but on his basic right not to be the subject of a battery. Courts have long held that surgery without consent is unauthorized contact and constitutes the tort of "battery."

Consequently, the plaintiff argued that the trial court's interpretation of the statute was erroneous and his common law claim for battery should be unaffected. Secondly, if the trial court's interpretation was correct, the plaintiff argued that the statute was unconstitutional because it denied him a remedy for battery, denying him due process of law, equal protection and uniform application of the law.

While it is hard to understand the basis on which they ruled, the Appeals Court agreed with the plaintiff that it would be "absurd" to find that a statute, obviously intended to limit liability for defective consent, permitted a physician to operate without *any* consent as long as a reasonable, prudent person would have consented to the procedure. The underlying purpose of informed consent is to provide each individual patient with control over his or her own body. To *imply* consent because a reasonable person might consent but where this patient, in fact, did *not* consent, undermines the entire philosophy of informed consent. The problem, however, is that this seems to be precisely what the Utah statute requires. Other than the fact that application of the statute is absurd, the court does not seem to have strong reasoning on which to hold that the statute does not apply. The court develops a theory that the common law concept of "battery" is an intentional wrong, while the statute is designed to deal with harm occurring through "negligent wrongs."

What does "intentional" mean?

While this distinction gets the Utah court past the "absurdity" of the result in the *Lounsbury* case, it is not clear what this distinction will mean in the future. What, exactly, has to be "intentional"? Is it that the surgeon *intentionally* performs the surgery without any consent, or can the surgeon *intentionally* not supply certain information concerning risks of the procedure? If some court later decides that a surgeon's decision not to supply information about certain risks makes the damage a result of an *intentional* rather than a *negligent* action, what meaning does the statute have at all?

A second issue raised by the case was that the patient's wife consented to the surgery. Under Utah law, consent can be provided either by the patient or the patient's representative. The plaintiff pointed to another statute which provided that nothing in the Health Care Malpractice Act shall be construed to prevent any person 18 years of age or over from refusing to consent to healthcare for his own person upon personal or religious grounds. The patient claimed that allowing his wife to consent on his behalf deprived him of the right to make his own decision.

The court agreed with the patient's interpretation, but the court seems to overlook the fact that permitting a patient's representative to grant consent has to limit a statute, at least to some extent, which purports to provide that every person over 18 years of age has the right to refuse to consent. If the statute giving persons over 18 the right to determine if they will undergo procedures means that only the patient can consent, what was the point of the statute providing that a patient's representative can give consent?

The Utah Appellate Court created its own interpretation of the spousal consent statute. It ruled that the statute permitted the consent of the spouse only in cases of emergency or where a patient was otherwise unable to give his or her own consent. Mere temporary incapacity of the patient does not serve as justification in obtaining consent from the patient's spouse if there was a reasonable opportunity to obtain the patient's own consent. While a good result, the court is applying the statute in a way which looks more like an amendment than an interpretation.

A more easily reached conclusion

There was a simpler basis on which the Utah court could have come to this conclusion. The statute permitting spousal consent goes on to provide that "*such written consent* [of the spouse or another agent] *shall be a defense to an action against the healthcare provider based upon failure to obtain informed consent unless the patient...shows by clear and convincing proof that the execution of the written consent was induced by the defendant's affirmative acts of fraudulent misrepresentation or fraudulent omission to state material facts.*"

Under the circumstances of the *Lounsbury* case, the patient had said that he would not consent to an operation until he had had a chance to fully discuss it with his surgeon. The surgeon did not discuss the matter with the patient but instead took advantage

of his drugged state to obtain a consent form from his wife. When the patient's wife was asked to sign a stack of papers including a consent form, she wrongly concluded that her husband must have agreed to the surgery. Surely, this was a fraudulent misrepresentation on the part of the surgeon which would have rendered the wife's consent invalid.

As informed consent cases begin to develop, perhaps they will provide more specific answers to what has to be discussed in particular circumstances. At the moment, most of these cases deal with issues like the ones raised in Utah in which a patient's rights are clearly violated and the courts are enforcing *basic* rights. Meanwhile, healthcare providers must try to act in good faith to share with patients the facts relevant to the patient's decisions. To a large extent, what must be disclosed to a patient will be determined by the standard of care. What do CRNAs and other healthcare providers do in similar circumstances?

NOW AVAILABLE

RESOURCE DOCUMENT FOR NURSING CARE OF THE TRAUMA PATIENT

Because nursing holds a unique and important place in the care of the trauma patient, this document was developed to assist nurses in planning, developing, implementing, and evaluating the nursing components of a trauma program or system. Nursing care must be commensurate with the type and severity of the injury. Effective trauma care is typified by a consistent, coordinated approach within an organized system of care. The approach by the health care professional to the traumatically injured patient is of key importance. By virtue of their education, experience, and continuous provision of care, nurses offer a unique perspective and understanding of trauma programs and systems.

In 1990 the Trauma Nursing Coalition was organized by the Emergency Nurses Association (ENA) to address the nursing care components of an organized trauma care program. Together these six organizations—ENA, the National Flight Nurses Association (NFNA), the Association of Operating Room Nurses (AORN), American Association of Critical Care Nurses (AACN), Association of Rehabilitation Nurses (ARN), and the American Association of Nurse Anesthetists (AANA)—represent over 160,000 nurses. Representatives from these associations collaborated to describe the multiple aspects of care that patients require as they move through the trauma continuum from prehospital care to reintegration into society. The ***Resource Document for Nursing Care of the Trauma Patient*** is a product of their collaborative effort and is a testimony to the commitment of the nursing profession to decrease trauma patient morbidity and mortality.

EMERGENCY NURSES ASSOCIATION

AACN CRITICAL CARE

☑ YES! Send my copy of the ***Resource Document for Nursing Care of the Trauma Patient*** to the following address:

NAME

ADDRESS

CITY, STATE, ZIP

Send all orders to: **AORN, Inc.**
Attention: Accounting
10170 East Mississippi Avenue
Denver, CO 80231

Number _____ of Copies *X* $10.00 each
= **PAYMENT ENCLOSED:** _____
(U.S. dollars only, drawn on a bank with a U.S. affiliate)
OR charge my order to MasterCard or Visa:*

CARD NUMBER

EXPIRATION DATE

SIGNATURE

*Charge orders may also be placed by calling (303)755-6300.

ALLOW 2-3 WEEKS FOR SHIPPING

ARN

NATIONAL FLIGHT NFNA NURSES ASSOCIATION

AANA