

Who Decides?

A guide for clinicians about medical decision-making

—by Therese M. Flynn, Esq. Associate General Counsel, Lifespan Corporation

The concept of informed consent is one of the cornerstones of the physician-patient relationship and is grounded in the individual's fundamental right to control medical decisions affecting his or her body.¹ In cases where an adult patient has full capacity to make informed medical decisions, the process of seeking consent hinges on the physician's explaining all the options, risks and benefits of the procedure, and guiding the patient to make a decision. When the patient is a minor or otherwise lacks the capacity to make an informed medical decision, the process of seeking informed consent becomes more complicated as the physician must locate a surrogate decision-maker to act on the patient's behalf.

The purpose of this article is to describe the legal and ethical principles physicians should consider when working with patients, their families and friends to

make medical decisions. The article also suggests how physicians should document the process of seeking informed consent in difficult cases so as best to minimize the risks of litigation. For further guidance, physicians should refer to their Lifespan hospital's Policy on Medical Decision-Making, and should always feel free to call Risk Management or the Office of the General Counsel for advice.

Determining Capacity to Consent

Often the most difficult issues in medical decision-making arise when a physician encounters an adult patient with questionable capacity to consent. Questions of capacity to consent may arise when a patient refuses a procedure, test or treatment that is deemed necessary by the health care team, or when a patient insists on leaving the hospital before treatment is completed. The question of capacity may also arise when the patient exhibits behavior such as confusion, irrationality, extreme vacillation, and/or language barriers. It is important that the attending physician not interpret rejection of a recommended course of treatment as a sign of the patient's incompetence to make medical decisions.

When questions of capacity do arise, it is worth asking as a first step whether the patient has been judged legally incompetent in a court of law, in which case the patient would have a legally appointed guardian to make medical decisions on his or her behalf. In such cases, the physician would not have to engage in an assessment of capacity since incapacity would already be established.

In the majority of cases, however, when questions of capacity arise, the attending physician must engage in a fact-sensitive analysis to decide whether the patient has an understanding grounded in fact of his or her condition and the consequences of accepting or refusing medical treatment.

The attending physician can and should use information gathered by other members of the health care team to assess the patient's capacity, but may not delegate ultimate decision-making in this area.

When determining capacity to consent, the attending physician may find a psychiatric consult useful, but such a consult is not required. In any case, the attending

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Lifespan Risk Management

www.lifespan.org/risk

167 Point Street
Suite 170
Providence, RI 02903
tel: (401) 444-8273
fax: (401) 444-8963

physician (or the psychiatrist if a consult is requested) should, at a minimum, consider the following factors in assessing the patient's capacity to make medical decisions:

- 1 Patient's ability to understand the nature and severity of his/her illness and the likely prognosis;
- 2 Ability to understand the treatment, procedures, tests or other care under consideration, and the relative risks and consequences;
- 3 Ability to make informed and deliberate choices regarding his/her care and treatment;
- 4 Ability to understand the consequences of the decision; and
- 5 Whether the presence of depression or other mental illness is seriously impairing the patient's decision-making ability.

Consideration of these factors should be noted prominently in the patient's medical record.

If the patient is determined to have capacity to consent, approval of his or her decision by the attending physician, the patient's family or other surrogate is not required. If the attending physician feels uncomfortable carrying out the patient's wishes, he or she may transfer the patient to another physician.

Finally, if a patient currently lacks capacity, but has previously executed a Living Will² containing explicit instructions covering the medical situation at hand, then the Living Will should control.

Identifying the Surrogate Decision-Maker for Adults

When an adult cannot give informed consent and has not left a Living Will (or does not have a Living Will that addresses the situation at hand), the physician must try to identify a surrogate decision-maker to make decisions for the patient.

The physician should first consider whether the patient has appointed an agent to act as decision-maker under the State's Health Care Power of Attorney Act³, in which case the agent would be considered the decision-maker. Additionally, if the patient has a court-appointed guardian with authority to make medical decisions, the guardian would be considered the decision-maker. If there is no Power of Attorney, no guardian, and the patient cannot consent, the physician needs to consider the context of the patient's life and to try to identify a family member, friend, or other person who is able to make decisions on behalf of the patient, or, at the very least, to offer information about how the patient would have approached making decisions of this nature if able.

Rhode Island law offers little guidance on identifying surrogate decision-makers for medical decisions. As a point of reference, some physicians may find it useful to consider the hierarchy of persons authorized under the State's Uniform Anatomical Gift Act⁴ to make an anatomical gift of all or a part of a decedent's body. This hierarchy is, in order of priority: 1 spouse; 2 adult son or daughter; 3 either parent; 4 an adult brother or sister; 5 grandparent; or 6 guardian of the person of the decedent at the time of death. It should be stressed, however, that this hierarchy is binding only in the context of anatomical gifts; in other medical contexts, many providers,

Rhode Island law permits married minors and anyone sixteen or older to consent to "routine emergency medical or surgical care."

including the Lifespan hospitals, have policies that value the input of friends and more attenuated family members who have a clear connection to the patient and act in the patient's best interest.

Absent a clear hierarchy, the hospital may face many potential surrogate decision-makers for a particular patient. In such cases, the physician or other provider should stress the need for the group to come to a consensus and to appoint a spokesperson. In the event of conflict among surrogates regarding the patient's wishes, a series of discussions should be initiated. This conflict resolution procedure must be expedited and may involve assistance from appropriate personnel such as social workers, risk managers, lawyers, or the hospital ethics committee.

In cases where the hospital, after a diligent search, is unable to locate a surrogate, the attending physician must consult with the chief of service (or his/her designee) and with hospital administration or Risk Management about a course of action. Such consultation shall involve full exploration of whether any reliable evidence exists of what treatment the patient, when capable of giving consent, would have wished to receive under the existent circumstances. In the absence of such reliable evidence, the consultation will also explore whether the attending physician believes the proposed treatment will benefit the patient, or whether the physician believes it will significantly burden the patient with no hope of a corresponding benefit. If there is ambiguity or lack of

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consensus related to these criteria, the team may find it helpful to consult the Hospital Ethics Committee.

Additionally, in certain cases, the physician may recommend that the patient's family or friends seek judicial appointment of a guardian to serve as surrogate decision-maker, or judicial review of a proposed course of treatment. In rare cases, the physician or hospital may initiate guardianship proceedings.

Special Rules for Minors

In Rhode Island, persons below age eighteen usually cannot make medical decisions. The general rule is that parents must consent on behalf of their children. Other caregivers cannot consent unless specifically authorized to do so (preferably in writing) by the parent.

In some cases, however, minors can give consent. For example, Rhode Island law permits married minors and anyone sixteen or older to consent to "routine emer-

Physicians should feel free to call Risk Management or the Office of the General Counsel for guidance.

gency medical or surgical care."⁵ Additionally, a minor can petition the courts for emancipation. If a judge decides the minor satisfies the criteria for emancipation, physicians should allow the minor to give consent. Physicians should also ask such minors for a copy of the court order of emancipation and should include this in the medical record. Finally, in certain cases, the law permits minors to seek treatment or advice concerning family planning, substance abuse and infectious disease without seeking parental consent. If a minor requests care in one of these areas and questions of consent arise, the attending physician should contact Risk Management or a hospital attorney.

Importantly, Rhode Island law requires a parent to consent to a minor's abortion unless the minor is legally emancipated or unless certain statutory exceptions to notification are met.⁶

Documentation

The level of detail the attending physician should use in documenting the decision-making process in the patient's medical record will vary depending on the circumstances of the case. In general, the more complicated the process of identifying the decision-maker and making the medical decision, the more detailed the documentation should be.

When a surrogate decision-maker is required, the record should document the steps taken to locate one. If a spokesperson is representing a group of potential surrogate decision-makers, the medical record should note the identity of this spokesperson and the fact that he or she purports to be speaking for the larger group. When a second medical opinion is requested, this second opinion should be noted in the medical record.

Additionally, the attending physician should document the clinical appropriateness of medical decisions that are recommended and/or implemented. The discussion of clinical appropriateness in the medical record should include a summary of why the benefits of a particular procedure outweigh the risks. The medical record should also reflect any available evidence of the patient's wishes as they pertain to the decision to be made.

Conclusion

This article should serve as a resource for physicians working through complex issues concerning informed consent and surrogate decision-making. Physicians should also become familiar with their hospitals' policies on medical decision-making, end of life care and related issues, and should feel free to call Risk Management or the Office of the General Counsel for needed guidance and assistance. Additionally, the hospital ethics committee can provide invaluable support to physicians, other caregivers, patients, family and friends faced with difficult medical decisions. In general, physicians should in their daily practice strive to understand and apply the legal and ethical principles of informed consent in order to provide care in the most educated and compassionate way possible.

¹ This right stems from the right to privacy arising from the due process clause of the federal constitution and other constitutional guarantees. See U.S.C.A. Const. Amend. XIV. The right is not absolute, and must be balanced against certain governmental interests.

² See R.I. Gen. Laws, Chapter 23-4.11.

³ R.I. Gen. Laws, Chapter 23-4.10.

⁴ R.I. Gen. Laws, Section 23-18.6-3.

⁵ R.I. Gen. Laws, Section 23-4.6-1. The law does not define "routine emergency."

⁶ R.I. Gen. Laws, Section 23-4.7-6. ☀

Risk Management staff

is available to provide risk management education to clinical and hospital departments, medical staff and meetings at any one of the Lifespan affiliated institutions. Foundation requests should be directed to **Peggy Martin, Sr.** Risk Management Coordinator, Lifespan Risk Services.

E-mail: pmartin2@lifespan.org Phone: 444-6491

Lessons Learned

—by Annette Bender, Tate & Associates,
Education Coordinator for Risk Management Foundation

The purpose of this section is to share summaries of closed cases that have occurred in the New England area and represent real life issues that provide proactive risk management educational opportunities. The cases used may come from Lifespan affiliates, or other institutions or practices, but should have some relevance to situations that you may encounter.

CASE

Over Easter weekend, a 74-year-old retired businessman with metastatic prostate cancer had a ureteral stent placed to relieve obstruction. The staff urologist who performed the procedure signed off at its conclusion.

The patient had significant pain following the procedure and was admitted overnight for observation. The resident on duty consulted by phone with the urologist. Subsequently, two radiology residents reviewed the post procedure KUB (kidneys, ureter, bladder X-ray) to check the placement of the stent and (mistakenly) judged it to be properly placed. The next afternoon, a radiology fellow confirmed the residents' (incorrect) judgment and the patient was discharged home.

On Monday morning, after two days of pain, the patient went to the hospital Emergency Department (ED). A repeat KUB suggested that the stent was not in proper position, and an abdominal CT scan was ordered to check the placement. Before the test was performed, the patient was assigned to a bed in the inpatient unit, but was kept in the ED to await his CT. During a nine-hour wait, the patient's wife repeatedly complained to the ED staff that her husband was in severe pain. The patient received analgesics in response. No explanation was given to the patient or his wife for the delay.

At 6 p.m., the ED resident who had ordered the CT checked on the status of this patient. He discovered that the patient had been removed from the CT schedule because another patient with the same name had received a scan and had been discharged. He informed the patient that this name mixup was the cause of the delay and scheduled an immediate CT scan.

The scan showed that the stent had perforated the patient's ureter. A percutaneous nephrostomy was performed urgently under conscious sedation and a drain placed. Despite the sedation, the patient's pain made positioning difficult, and he needed to be restrained. Near the conclusion of the procedure, the patient suffered a respiratory and then a cardiac arrest. He sustained severe brain damage.

At the request of the family, a conference was convened several days later to review the event. The radiology and urology residents presented their part of his care but could not agree on the chain of responsibility.

DAMAGES

The patient died four months later. Although his prognosis had been poor prior to the perforation, his death was attributed to the complications related to his conscious sedation.

LIABILITY

Suit was brought against the hospital, six physicians, and a nurse. Two prominent complaints expressed by the patient's wife in her deposition were that 1) her husband was kept waiting while in extreme pain and 2) that her family received no explanation of what had occurred during the family conference after the event.

RISK MANAGEMENT ISSUES

With the patient's report of pain, the urology resident alerted the attending, observed the patient overnight, and reviewed the KUB before discharging him.

Patients can provide early warning of problems when they are instructed how to collaborate in their care by reporting unexpected side effects of treatment.

Better systems for following up on patient care in the ED were needed to avoid "losing" this patient. Repeated requests for pain control medications were cues to staff to re-evaluate this patient's status.

Physician and nursing staff are responsible for tracking orders written for patients. Older patients are traditionally less assertive about getting their needs met in a medical setting. Patient service systems may need to provide flags to alert staff to heighten vigilance for patients who may not be able to advocate for themselves.

Plaintiffs in professional liability cases often cite feelings of abandonment by their providers as a factor in their claim. In this case, the patient's long wait for the diagnostic procedure while in "significant pain" was a prominent point in the plaintiff's complaint.

Patients can tolerate unavoidable delays better when the hospital staff or provider routinely updates the patient as to the reasons for the delay.

The "same name" delay in obtaining diagnostic services in the ED pointed to the need for changes both in staffing systems and in physician follow-up, but the excuse didn't appease the patient's dissatisfaction.

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Reproaching the hospital system in front of the patient may only serve to undermine the credibility of care providers. Instead, a response that objectively analyzes what went wrong may help to assuage frustrations.

The family in this case requested a meeting to help them understand what had occurred, but it may not have helped. A patient/family conference following an adverse event may contribute to averting a claim when it is well-planned and carried out using good communication methods. To help both sides benefit from such a meeting, consider:

- ▶ Involving your risk manager,
- ▶ Selecting a single spokesperson from the care team,
- ▶ Reviewing and reaching consensus among the care team about the chain of events,

- ▶ Allowing time for the patient/family to express their concerns,
- ▶ Acknowledging and apologizing for the patient or family's distress without pointing fingers or affixing blame, and
- ▶ Offering emotional support.

OUTCOME

The suit was settled in the high range.

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Risk Management Q&A

Q *Some patients say they have a durable power of attorney for healthcare and some say they have a living will. What's the difference?*

A A living will and a durable power of attorney for health care (in Massachusetts, a health care proxy) are two different types of advance directives that must meet certain requirements under state law in order to be considered valid.

When a patient executes a health care power of attorney document, he or she names another person to act as his or her agent to make medical decisions in the event the patient becomes unable to make such decisions. If the patient wishes, he or she can include specific instructions in the document advising the agent about how to act in certain situations. If the power of attorney does not include such instructions or limitations, the agent is afforded full legal authority to make medical treatment choices the patient could have made if capable, including but not limited to decisions about withholding or withdrawing life-sustaining procedures in the event of a terminal illness.

In a living will document, the patient can instruct the physician about whether to withhold or withdraw life-sustaining procedures in the event the patient develops a terminal condition and cannot communicate his or her wishes. A living will is not as flexible as a health care power of attorney because it only applies to withholding or withdrawing care at the end of life, and there are many other types of medical decisions that might need to be made. Also, it is difficult for a person executing a living will to anticipate all the treatment decisions that may arise at the end of life. Thus, a living will may not provide specific enough instructions to be useful to a physician. On the other hand, the discretion invested in a health care agent provides strong legal grounds for the agent to make any decision deemed to be in the best interest of the patient.

Q *I've heard that adding an addendum to a patient's record can increase my liability. Under what circumstances should I use one and when shouldn't I?*

A Addenda are properly used to: **1** document additional patient care information that was not recorded at the time of the event; and, **2** to correct inaccuracies previously recorded. Timing is important. If an addendum is being considered, it should be added as soon as possible after the event. An addendum more than a day or two after the event almost always appears to be self-serving, especially if there has been an adverse event with that patient.

Addenda can get providers into difficulty if: **1** it appears that the provider is attempting to change the facts; or, **2** it appears the provider is trying to justify whatever care was given, rather than providing information about the patient's care. Practitioners should never use an addendum to explain their role or to deflect blame onto someone else. While it may seem as though such an explanation will protect the provider from liability, it inevitably increases everyone's risk of being successfully sued.

When making an addendum,

DO

- ▶ Document the current date and time
- ▶ Write "addendum" and state the reason, referring back to the original note
- ▶ Be objective and factual

DO NOT

- ▶ Use it to explain how carefully you treated the patient
- ▶ To blame yourself or others after an adverse event ☀

“Case Studies in Risk Management,” A monthly CME program for physicians

Second Tuesday of the month, Collis Conference Room, 12 noon to 1pm

The Rhode Island Hospital Department of Continuing Medical Education and the Risk Management Department will present a monthly one-hour program for physicians. Case studies from actual and potential claims will be discussed and pertinent loss prevention strategies will be reviewed.

Bring your lunch. Cold drinks and dessert will be provided.

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Rhode Island Hospital designates this continuing medical education activity for a maximum of 1 category I credit toward the AMA Physician’s Recognition Award.

Each physician should claim only those credits he/she actually spent in the educational activity.

Rhode Island Hospital fully intends to comply with the legal requirements of the Americans with Disabilities Act. If any participant of this conference is in need of accommodation, please contact the Rhode Island Hospital CME office at (401) 444-4260.

This CME activity is also designated for a maximum of 1 category I credit in Risk Management.

Program Dates

May 11

June 8

July 13

August 10

September 14

October 12

November 9

December 14

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editorial committee chairperson: Peggy Martin

committee members: Paul Adler, Joan Flynn, Rick Almeida, Joseph Melino and Roland C. Loranger

design: Ellen Watt/IGN

Lifespan
Risk Management
167 Point Street
Suite 170
Providence, RI 02903



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