# Informed Consent: Court Looks At Nursing Responsibilities.

The patient came to the medical center with kidney stones. Because the stones did not pass, surgery was necessary.

The center's policy was to require separate informed-consent forms for surgery and for anesthesia.

The nurse's role was limited to verifying that consent had been given, that is, before the nurse signed the informed-consent form as a witness to the patient's signature the nurse was expected to check to be sure that:

*Information about the surgery was provided to the patient prior to surgery;*

*An explanation was provided to the patient by the anesthesia provider;*

*The patient or the patient's healthcare surrogate decision-maker gave consent to treatment after discussion;*

*The patient or surrogate was given the opportunity to ask questions about the proposed treatment and that all of these questions were answered fully;*

*All the blanks on the form were filled in with the necessary information; and*

*The patient or surrogate signed the form.*

The medical center's policy went on to say that the physician and the anesthesia provider were to obtain consent from the patient after they had advised the patient as to the risks, drawbacks, complications and expected benefits of the surgery and the method of anesthesia.

***The medical center claimed the nurse met the requirements of the medical center's informed-consent policy by getting the patient to sign a blank consent-to-anesthesia form and then signing it as the witness to the patient's signature.***

***However, it is not clear how that was anything more than an empty gesture, given the fact the patient had received no information about anesthesia before he signed the form.***

COURT OF APPEALS OF ARKANSAS
September 7, 2011

**Nurse Merely Had the Patient Sign The Anesthesia Consent Form**

The nurse got the patient to sign an anesthesia-consent form which was blank as to the type of anesthesia that was to be used. Nor had the anesthesia provider, a certified registered nurse anesthetist (CRNA) even met with the patient or given the patient any information before the patient signed the form at the nurse's behest.

The CRNA reportedly had trouble administering the spinal block and made quite a number of puncture wounds in the patient's back. Afterward a physician diagnosed a serious inflammatory condition known as arachnoiditis that was caused by the multiple spinal punctures.

The Court of Appeals of Arkansas saw grounds for a lawsuit by the patient against the medical center.

**Informed Consent Nursing Responsibilities**

The Court agreed with the medical center it is not a nursing responsibility to obtain informed consent for anesthesia. That was the legal responsibility of the CRNA who was an independent contractor and not an employee of the medical center.

However, the medical center's policy for its employee nurses in regard to informed consent went beyond the mere formality of having the patient put a signature on the necessary paperwork.

It is a nursing responsibility, not to provide the information necessary for informed consent but to verify that the patient has been given the necessary information by the provider to make a truly informed decision to consent to surgery or surgical anesthesia. That essential nursing responsibility was completely absent in this case, according to the Court.

An invalid informed-consent document is no informed consent at all and no legal defense to liability if the patient claims he or she would not have had the procedure if he or she had actually known what was really involved. **Villines v. North Arkansas Reg. Med. Ctr., __ S.W. 3d __ , 2011 WL 3916143 (Ark. App., September 7, 2011).**

# O.R.: Perioperative Nurse Advocated For The Patient.

After a CT scan revealed a mass in the patient's colon the physicians decided he needed to have surgery.

He was taken to the surgical suite and placed under anesthesia at 9:30 a.m. Then several hours went by while the general surgeon who was in the operating room attempted to contact a colorectal surgery specialist to come and take over the case.

At 12:30 p.m. a colorectal surgeon came in, examined the large intestine with a sigmoidoscope and continued as the surgeon on the case.

***At 4:30 p.m. one of the O.R. nurses voiced her concern to the colorectal surgeon over the fact the patient had been in the lithotomy position for a number of hours and should be repositioned.***

***The surgeon acknowledged the nurse's concerns but did not change the patient's positioning.***

COURT OF APPEALS OF KENTUCKY
September 23, 2011

At 10:40 p.m. the colorectal surgeon finished the case. It was discovered there was no pulse in either of the patient's legs. Circulation soon resumed in the right leg, but not the left. The left leg had to be amputated below the knee a week later.

The Court of Appeals of Kentucky approved a jury verdict which found no negligence by the hospital. The nurse, a hospital employee, had done her legal duty by advocating for her patient.

The colorectal surgeon, an independent contractor, was also found not liable due to technical problems with the patient's experts' formulation of how the medical literature defined the standard of care for padding and positioning a surgical patient in 2003 when the incident occurred. **Carroll v. Univ. Med. Ctr., __ S.W. 3d __, 2011 WL 4407449 (Ky. App., September 23, 2011).**