Legal Issues in Nursing

Name

Institution

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From the case study, Ally underwent two surgical procedures. The first procedure involved her routine colonoscopy and biopsy because she was suffering from Crohn's disease, and the second procedure involved emergency laparoscopy as a result of the complications of the first procedure. As a result, Ally's procedures and their prognoses are punctuated with legal issues that amount to litigation and compensation.

Consenting to Treatment

Forrester and Griffiths (2015) contend that for the procedures to be performed, a valid consent must be obtained from the patient. The following are the elements of a valid consent:

I. Free and voluntary: The consent should basically be free from coercion, fraud, misrepresentation or duress (Beausoleil's case [1964] as cited in Forrester & Griffiths, 2015; Cavell, 2007; Cooke, 2011).

II. Cover the procedure: The patient consents only to one procedure or medical treatment. In case of another procedure, the medical staff should seek fresh consent for that procedure (Cooke, 2011; Murray v McMurchy [1949] as cited in Forrester & Griffiths, 2015).

III. Informed Consent: The practitioner should provide a thorough explanation of the nature and type of medical procedure or treatment the patient should undergo, and the risks versus benefit of taking the procedure. The nature and effect of the information given should facilitate adequate decision-making from the patient (Cavell, 2007; Cooke, 2011; Rogers v Whitaker [1992] as cited in Forrester & Griffiths, 2015).

IV. Legal capacity: The patient must be of legal age and of sound mind and intelligence for the consent to be valid. The validity also encompasses verbal, written or implied consent (Cooke, 2011; Forrester & Griffiths, 2015).

The satisfaction of the four elements above makes up a valid consent to medical treatment or procedure. The lack of satisfaction of the elements amounts to legal litigations, as noted by Kloczko, 2006). The lack of a valid consent always creates litigations where the defender may be accused of trespass, forced imprisonment, assault, battery or even negligence. For the first procedure, Ally’s father consented to the procedure since Ally was not of legal capacity to consent to the procedure (<18 years). However, since common law is ambiguous on the age of consent to treatment to young adults, Ally could have consented to the procedure herself because being in study year 12 gives her the mental competence and intelligence to consent to medical procedures without prior approval from her father (Forrester & Griffiths, 2015 “Common Law”).

Ally was undergoing an invasive procedure that required both verbal and written consent from her father (Forrester & Griffiths, 2015). This aspect of the consent is not captured in the case, and can be grounds for consent invalidation. Colonoscopy and biopsy are invasive procedures, and Forrester and Griffiths (2015) contend that they may be associated with significant complications. The lack of evidence of written consent may result to accusations of trespass and negligence as happened with *Ljubic v Armellin* (Cited in Forrester & Griffiths, 2015 p. 149). Furthermore, despite Ally’s father consenting to treatment, she was not provided with basic information regarding the prognosis of her status after the surgery and risks associated with colonoscopy and biopsy. Forrester and Griffiths (2015) assert that medical staff has a duty to

warn patients of risks associated with medical treatments and procedures. Providing this information is part of the process of obtaining consent.

The ‘failure to warn’ for the case of Ally’s doctor amounts to negligence, which Freckelton (2006) and Koczko (2006) consider a breach of the duty of care, since the doctor has privileged information on therapeutics that the patient may not be aware of. Furthermore, the Australian Commission on Safety and Quality in Health Care (2008) and the National Health and Medical Research Council (2004) consider the act of withholding patient information a violation of the patient’s right to safe and quality health. This violation amounts to a felony unless the *defendants* prove that by withholding information from the patient, they meant no harm to the patient. Besides accusations of negligence, the defenders can also be charged for assault and battery (*Rogers v Whitaker* [1992] as cited in Forrester & Griffiths, 2015), since the patient suffered harm in the form of physical (abdominal distention and pain), emotional and mental (fear and anxiety) challenges.

In the second procedure (emergency laparoscopy), the patient consented to therapy after realizing her condition was deteriorating. Ally gave her verbal and written consent to the procedure because she was frightened. The “fright” takes away her mental competence and intelligence required to consent to therapy. According to Forrester and Griffiths (2015), Ally’s mental status and competence at the time she signed the consent proves that she was coerced or misrepresented and under duress when she consented to the therapy. This nullifies the element of “free and voluntary” to consenting, making the staff liable to counts of battery, assault, and forceful imprisonment since the patient was functioning well at the time. As a result, the team did not meet the four elements of consenting to validate Ally’s decision to comply with the procedure (Cavell, 2007). However, the staff can cover themselves under the gist of

"emergency" and the doctor had established that Ally's survival depended on the procedure. As a result, their risks versus benefit analysis informed their decision to institute the procedure to save Ally's life. Ally's case is punctuated with legal scenarios of trespass, negligence and medical malpractices.

Trespass

According to Forrester and Griffiths (2015), trespass encompasses battery, forceful imprisonment and assault.

Assault

- "Intentional tort involving the creation in the mind of another the fear of imminent and unwanted physical contact" (Forrester & Griffiths, 2015). The patient should basically feel threatened without the need for physical contact or touch by the perpetrator. Assault may also occur if the individual feels that they will be subjected to some of treatment of medical conduct whose consent has not been provided.
- The lack of valid written consents before the procedures were initiated could be perceived as assault. The institution of the procedure on Ally's body could be perceived as assault, since consenting to invasive procedures requires express verbal or written consent (Cooke, 2011; Forrester & Griffiths, 2015).
- However, Forrester and Griffiths (2015) proof of assault requires the plaintiff to demonstrate that defendant had the intent and means to carry out the assault. And if Ally cannot provide adequate proof, the case becomes nullified.

Battery

- "Actual physical contact with the person of another" (Forrester & Griffiths, 2015). No proof is required that such proof was offensive or harmful.

- Ally’s first and second procedures can be considered as battery. In the first procedure, evidence of written consent was absent, invalidating the consent and resulting in battery (Forrester and Griffiths, 2015). For second case, the grounds for battery will revolve around the patient being coerced or misrepresented to give consent because of the threat of her condition to survival (Cavell, 2007; Cooke, 2011). However, battery claims for the second procedure can be contested or overturned on grounds of “emergency,” which was carried out for Ally’s survival (Mainhoff, 2010).

False Imprisonment

- “Unlawful restriction of a person’s movement or freedom movement” (Forrester & Griffiths, 2015). It may also mean beginning a medical intervention or procedure without a valid consent (Cooke, 2011).
- The two procedures were carried out without express written consent from the patient. The invalidation of the consents given implies that the patient was falsely imprisoned, and the hospital and its staff may be sued for damages. Cobbs (2007) and Mainhoff (2010) contend that as long as a procedure is done without the patient’s consent to adverse damage to the patient’s health or to save their lives, it does not amount to any litigation as proof of otherwise would have resulted in serious health problems.

Emergency

Ally’s second procedure (open laparoscopy) can be considered as carried out under the “gist of emergency.” According to Forrester and Griffiths (2015), “emergency procedures are carried out if the adult patient has impaired health capacity, there is an impending risk to the patient’s life or health, or there would be substantial pain or distress to the adult arising from the lack of the procedure.” Ally’s complications from the first procedure required emergency

intervention because her condition kept deteriorating and there was imminent danger to her life and health (Mainhoff, 2010). As a result, the proof of emergency overturns the litigations of trespass in the second procedure.

Negligence

"Negligence is a civil action under the law of torts where healthcare professionals and institutions become liable for harm or injury caused to a patient or client in the course of care" (Forrester & Griffiths, 2015). Kloczko (2006) contends that litigations as a result of negligence can emanate if there is evidence regarding:

I. Duty of care: There must be a relationship between the patient and the healthcare professional and evidence of contact between them.

II. Breach of duty of care: The health professional failed to act within the reasonable standard of care. Breach is evident from professional opinions of peers, and the application of the Bolam principle (Forrester & Griffiths, 2015).

III. Harm or injury to the patient: The action of the professional should have resulted in loss or injury that can be easily be established. The court prosecution should offer irrefutable proof that Ally suffered emotional, mental or physical injury (Forrester & Griffiths, 2015).

IV. Causation: The cause-effect relationship between the actions of the professional and the injury or loss should be established. The court should determine the principle or test to be adopted to determine the causation.

Ally can be suing the hospital and the staff for damages for the following incidences:

- The staff failed to adequately warn Ally of the risks associated with the laparoscopy and biopsy. Evidence of breach of standard of care (Forrester & Griffiths, 2015).

- Sharon failed beyond reasonable doubt to identify Ally's slightly leaking bowel immediately she was transferred from the emergency unit.
- After noticing Ally's observations to be behind schedule, Sharon leaves out the details from her observation chart.
- The hospital significantly delayed Ally's admission for routine colonoscopy and biopsy.
- The staff do not check Ally's state of mind before seeking her consent to emergency open laparoscopy.
- Sharon's end-of-shift was rather haphazard and amounted to negligence.
- It was negligence on the part of Sharon to post her end-of shift reflections on social media. Her disregard for patients' privacy and confidentiality compromised Ally's autonomy, causing significant injury (Ally's insistence on discharging herself from the hospital and her refusal to continue with treatment).
- The above scenarios tamper with Ally's rights to access quality and safe care.

Refusal to Treatment

The Medical treatment Act (1988) provides grounds for refusing treatment. Following Ally's knowledge that her routine colonoscopy and biopsy surgeon had a history of medical errors, she sought to refuse treatment at the hospital. Her decision was also influenced by the Sharon's social media post regarding the interaction between Sharon and her (Ally). Rothschild (2007) and Butson, Shircorem and Butson (2013) contend that Ally has the capacity and valid grounds to refuse further treatment in that hospital. However, since she is 17 years (<18years), she will not be able to make the decision herself, but would seek her father's approval as legal agent to approve her refusal (Medical Treatment Act, 1988). Upon receiving the application to terminate the therapy, the court may order a thorough evaluation of Ally to determine the risk

versus benefit of her refusal. However, the court may invoke the Gillick competence (common law) to refuse Ally's refusal to continue with treatment if it finds reasonable grounds that she is better off with treatment than without. Furthermore, the hospital will be forced to carry vicarious liability for the Ally's condition and will pay damages to compensate the plaintiff according. Wodak (1998) contends that compensation and firing some of its staff (Sharon and the first surgeon) may be some of damage control to the institution.

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