KASTAMONU MEDICAL JOURNAL

Letter to the Editor

DOI: 10.51271/KMJ-0159

Kastamonu Med J. 2024;4(3):131-132.

Who first? Should the surgeon prioritize the patient's benefit or protect himself/herself?

Fatih Öner[1], Elif Kaya Çelik[2]

[1]*Department of Otorhinolaryngology Head and Neck Surgery, Faculty of Medicine, Kastomonu University, Kastomonu, Turkiye*
[2]*Department of Otorhinolaryngology Head and Neck Surgery, Faculty of Medicine, Tokat Gaziosmanpaşa University, Tokat, Turkiye*

Received: 23/04/2024 ◆ **Accepted**: 01/07/2024 ◆ **Published**: 01/09/2024

Dear Editor,

Some patients who present to the emergency department with specific health issues might lack the ability to provide legally acceptable, informed consent. Acquiring informed consent for potential interventions and surgical procedures may become challenging for physicians. The unique circumstances of the clinical emergency may present obstacles to achieving the main goals of the informed consent procedure, specifically the recognition of usefulness and patient autonomy.[1] In situations that require an urgent assessment and decision-making process, physicians may unfortunately find themselves alone in making choices.

Drug abuse is a situation that has an impact on healthcare communication between patients and medical professionals. The use of these substances, which affect a person's level of consciousness, results in impaired cognitive function and suppresses conscious awareness. This raises concerns about the patient's ability to make informed decisions and the doctor's legal protection.[2] Refugees who settle as a result of population circulation for a variety of reasons (food, war, political reasons) require health services. Irregular refugee influxes, which have recently impacted the world, may disrupt communication between patients and doctors. Here, we will discuss the problem based on two case examples we encountered.

CASES

In the first case, a 34-year-old male patient was admitted to the emergency department with complaints of swelling in the tongue and floor of the mouth, difficulty breathing, and an inability to feed. The refugee patient, who presented with no apparent medical condition, received intramuscular analgesics for toothache in the emergency room 7 hours ago. During the patient's physical examination, a swelling in the sublingual area forced the tongue to elevate towards the hard palate. The patient's mouth opening was limited, and there was only minor swelling in the submental region. The patient received contrast-enhanced neck computed tomography (CT). Despite extensive and severe swelling in the tongue and tissues beneath it, we did not detect any pouches of abscess. We decided to intubate the patient and closely observe them in the intensive care unit to ensure the airway remained secure, given the potential for the disease to advance quickly and the necessity of an immediate tracheotomy. We concluded that the patient, who had a preliminary diagnosis of Ludwig's angina or allergic drug reaction and who was determined to have Ludwig's angina during follow-up, should be intubated and kept under observation in the intensive care unit. During the laboratory examination, we detected amphetamine in the patient's blood. Several factors made obtaining consent for the patient's transfer to the intensive care unit challenging. The patient was a refugee, unfamiliar with the spoken language, had no family members present, and was under the influence of drugs. Additionally, obtaining informed consent for potential tracheotomies and subsequent surgical interventions was necessary.

The second case is a 42-year-old male patient who presented to the emergency department with self-inflicted gunshot wounds resulting from a suicide attempt that occurred one hour ago. A rifled gun bullet entered the patient's left buccal area, exited through the left cheek, and severely damaged the soft tissues. The patient exhibited a distinct circular defect measuring 2x2 cm when observed from inside the mouth. However, the bullet left extensive damage to the left half of the face, including tissue destruction and impairment of the left parotid gland, stenon duct, and facial nerve. The bone structures and teeth were well preserved. According to the drug panel, the patient's blood test indicated a significant presence of amphetamine. What is the appropriate method for obtaining informed consent before surgery for a patient with no family members present?

DISCUSSION

Informed consent forms prioritize a patient's awareness of the treatment procedure, knowledge of their health condition, potential predicted complications and alternative treatment options, collaboration between the patient and healthcare provider, mutual respect, and patient autonomy. These forms guarantee that patients provide informed consent for treatment. Traditional medical decision-making methods, which follow

Corresponding Author: Fatih Öner, fatihoner.ent@gmail.com

Cite this article as: Öner F, Kaya Çelik E. Who first? Should the surgeon prioritize the patient's benefit or protect himself/herself? *Kastamonu Med J.* 2024;4(3):131-132.

a paternalistic approach, may not adequately address these principles. In contrast, informed consent provides a more comprehensive approach.

The process of obtaining informed consent from a patient with cognitive impairment starts by evaluating their cognitive ability to provide consent.[2] Only after establishing the patient's cognitive capacity can, we acquire consent. Suppose the patient is determined to be incapable of providing consent. In that case, it is necessary to obtain consent from the patient's legal proxies or based on advance directives, in addition to patient consent, a simplified form of consent. It is important to continuously assess patients' cognitive abilities, desires, and consent during their treatment.

Physicians, however, encounter difficulties obtaining informed consent in situations where factors like drug abuse or language barriers impede effective communication. Obtaining informed consent for surgery has become an essential element of surgical practice. Patient information and the associated documentation are subject to specific legal requirements.[3] While vital situations are not a matter for discussion, there is a gray zone on applying informed consent procedures in situations where some capacity is questionable. Critical surgical emergencies that ENT surgeons frequently encounter include facial and neck traumas as well as deep neck infections. These conditions pose a significant threat to the patient's life. Because there are so many critical structures in this area, it has the potential to develop into clinical scenarios that could result in mortality. We contacted the refugee patient through the hospital's translator and obtained his consent. For both patients, we asked for a psychiatrist's opinion to determine whether the patients could assess reality because they were drug-positive.

CONCLUSION

When faced with issues related to the validity of a signature for informed consent, physicians should seek interdisciplinary assistance from other departments and health professionals to strengthen their medicolegal defenses while safeguarding patients' rights to information and treatment.

ETHICAL DECLARATIONS

Referee Evaluation Process

Externally peer-reviewed.

Conflict of Interest Statement

The authors have no conflicts of interest to declare.

Financial Disclosure

The authors declared that this study has received no financial support.

Author Contributions

All of the authors declare that they have all participated in the design, execution, and analysis of the paper, and that they have approved the final version.

REFERENCES

1. Nwomeh BC, Waller AL, Caniano DA, Kelleher KJ. Informed consent for emergency surgery in infants and children. *J Pediatr Surg*. 2005;40(8):1320-1325. doi:10.1016/j.jpedsurg.2005.05.019
2. Fields LM, Calvert JD. Informed consent procedures with cognitively impaired patients: a review of ethics and best practices. *Psychiatr Clin Neurosci.* 2015;69(8):462-471. doi:10.1111/pcn.12289
3. Hanson M, Pitt D. Informed consent for surgery: risk discussion and documentation. *Can J Surg*. 2017;60(1):69-70. doi:10.1503/cjs.004816