

Global Surgery Dilemmas: When Informed Consent Shifts - A Case Report of Gastric Perforation for Emergency Exploratory Laparotomy on Operating Table

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Abstract

Informed consent is an ethical and a legal requirement in surgical care. It must therefore be obtained before any surgical procedure- major or minor, elective or emergency, is performed. In emergency settings, the process of informed consent is complex, and oftentimes less satisfactorily executed. Although surgeons may encounter decline of informed consent by patients during such situations, rarely will the initially obtained voluntary consent be declined.

Here, we present a case of a 44-year-old referral from a peripheral clinic who initially consented to an exploratory laparotomy (Ex-LAP) for gastric perforation but later declined the procedure while on the operating table, at the time of anesthesia induction. The patient's condition rapidly deteriorated, and he succumbed to his illness. This case highlights the ethical and practical dilemmas faced by surgical care providers, especially in resource-limited environments when confronted with shifting patient decisions.

It, therefore, serves as a poignant reminder of the informed consent ethical and legal dilemmas healthcare providers may face in the struggle to advance universal access to timely, quality and affordable surgical care. Navigating such situations requires sensitivity, adaptability, and a commitment to respecting patient autonomy, even when time is of the essence. We recommend continuous medical education sessions about such informed consent dilemma, and establishment and functionalization of institutional ethical committees to assist in handling such dilemmas.

Keywords: *Informed Consent, Global Surgical Care, Emergency Exploratory laparotomy*

1. INTRODUCTION

In global surgery practice, informed consent is a vital component of patient care respecting their autonomy¹ - a fundamental bioethics principle. Moreover, obtaining informed consent is more linked to surgical care than any other medical discipline. Here, it is a process, rather not a mere signature on the form^{2,3}, and essential for both emergency and elective surgical procedures.

In emergency settings, however, obtaining informed consent is complex and challenged by a number of factors, making it barely satisfactorily done by most surgeons^{4,5}. Once obtained, it is of rare occurrence that the patient will change his mind and decline the previously voluntarily provided authorization a surgical intervention. This case report delves into a

particularly challenging scenario where a patient's consent for an Ex-LAP procedure shifted dramatically, raising questions about the intricacies of ethical practice in global surgery.

2. CASE PRESENTATION

2.1. Patient's History

“ON”, a 43 years male, a referral from a peripheral health facility, with a diagnosis of intestinal obstruction, for operative management, came in at our facility with a two-day history of progressive abdominal distension and pain more marked in epigastrium associated with multiple episodes of non-projectile vomiting of greenish-yellow non-blood-stained vomitus, failure to pass stool, and worsening general body weakness. However, he had no history of fever or any other systemic symptoms.

He had history of chronic gastritis, with a long-standing history of drinking alcohol (CAGE=2/4) and smoking cigarettes. However, he had no other known chronic illness, food or drug allergies and he was of unknown HIV serostatus. "ON" had no previous history of major surgical operations, major traumatic injuries, or blood transfusion. He was a peasant farmer, married with five children with no family or personal history of any mental disorders or other illness.

2.2. General and Systemic Examination

Generally, he was sick-looking, afebrile to touch with axillary temperature of 36.4 o C. He was mildly pale but not jaundiced, cyanosed or dehydrated, and had no edema or lymphadenopathies.

His abdomen was grossly distended, but without visible swelling or collateral vessels. He had generalized tenderness more marked at epigastrium with guarding and a dull percussion note but no rigidity or rebound tenderness. On cardiovascular examination, he had normoactive precordium, with cold and clammy extremities, prolonged capillary refill time of more than three seconds, and weak rapid pulse, being tachycardic at 141bpm. He had a Blood Pressure (BP) of 90/55 mmHg with normal heart sounds one and two heard. Respiratory examination revealed obvious respiratory distress and tachypnea of 28 breaths per minute with oxygen saturation (SPO₂) of 96% on room air. His chest was symmetrically expanding, with a centrally

placed trachea, resonant percussion notes all through, and vesicular breath sounds heard bilaterally with no added sound. He was lethargic and confused with GCS of 13/15 (motor response = 5/6, eye opening = 4/4, Verbal response = 4/5) on central nervous system examination with pupils equal and both reactive to light with no lateralizing signs. All other systems had normal examination findings and an impression of a 43 years old male with gastric perforation, in septic shock secondary to peritonitis was made.

2.3. Initial Resuscitation

A nasogastric tube was put in place for decompression, two liters of Ringers lactate bolus was given, urinary catheter was put to monitor urinary output. Also, intravenous ceftriaxone 2g stat and metronidazole 500mg stat dose were given. Blood samples were taken for full hemogram, serum electrolytes, and blood grouping and cross-matching, blood parasites for malaria.

2.4. Laboratory Investigations and Imaging

A full hemogram showed lymphopenia of 2300/l with elevated hemoglobin of 19.9g/dl, thrombocytopenia of 1060/l and the rest of the parameters were in normal ranges. Abdominal Ultrasonogram showed features suggestive of gaseous abdomen and peritonitis. An erect abdominal X-ray revealed about seven air-fluid levels, air under the right hemi-diaphragm, and diffuse haziness-ground glass appearance.

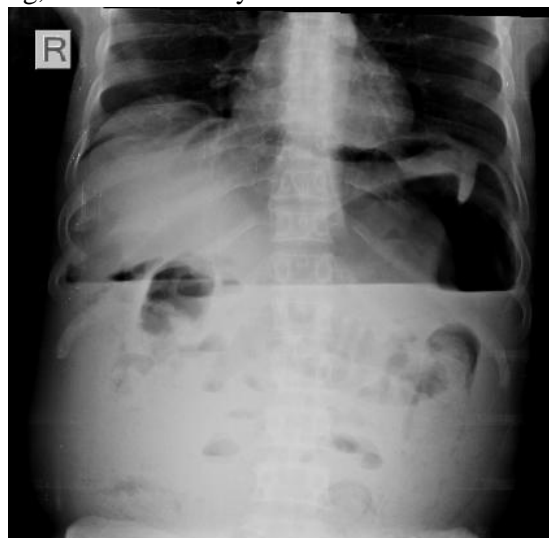


Figure 1. Patient's Erect Abdominal X-ray

A Diagnosis of acute abdomen with gastric perforation in septic shock was made and while still at the emergency department, and after stabilizing, "ON" provided initial consent for an

exploratory laparotomy (Ex-LAP). Due to the patient's deteriorating condition, the surgical team expedited the process to save valuable time.

2.5. Shift in Consent and Subsequent Events

At anesthesia induction, the patient expressed a desire for his parents to be present before proceeding with the Ex-LAP. He, the patient, signed not to be operated on against medical advice and the procedure was postponed to await the patient's parents at the cost of his life. He was then transferred to the High Dependency Unit (HDU) for close monitoring, continued fluid resuscitation and antibiotic therapy while awaiting his parents' arrival. Tragically, despite ongoing IV fluid resuscitation, the patient's condition rapidly deteriorated, and he succumbed to his illness within one hour.

3. DISCUSSION

On a bioethical ground, patients' autonomy must be respected at all times, irrespective of the prevailing circumstances^{1,6}. In the practice of global surgery, this calls for the obtaining of informed consent before any surgical procedure is performed, whether major or minor, emergency or elective. The process involves complete disclosure of all essential facts regarding the benefits and potential risks associated with the surgical procedure in addition to any possible alternatives, and comprehension of this information by the patient allowing him to make a voluntary choice of treatment option and offer authorization for the care to be executed^{2,3}. It is, therefore, an ongoing process, essentially built from good surgeon-patient relationships and a result of surgeons' good communication skills⁷.

Obtaining informed consent in emergency settings is a complex process, inevitably challenged by a number of factors⁴. Firstly, the majority of the patients presenting in these settings are critically ill, anxious, and not capable of making rightful decisions about their health care^{2,5,8}. Furthermore, because of the limited time available to reach decision-making, surgeons often times provide insufficient information to patients in need of emergency surgical care⁴. All these negatively impact the comprehension of the information provided and the provision of voluntary informed consent. In low-and-middle-income countries like Uganda⁹, overwhelming congestion at the emergency department compounded by lack of privacy, further curtails the process of informed consent. In this case, the patient (ON) presented acutely ill in hypovolemic shock and was unable to consent, and a decision was made to delay consent until he was stable following

resuscitation with intravenous fluids and antibiotics.

The presence of a trusted person, friend, or relative is often reassuring for patients who are anxious about the surgical operation⁶. For the case in question, the patient provided the initial informed consent in the presence of his young brother and other relatives. In some situations, however, especially where the patient is incapacitated to provide informed consent, the attending surgeon may be compelled to make a decision regarding the treatment option in the best interest of his patient. If not, a communitarian ("Ubuntu") approach is employed in which decision-making lies in the hands of family members, legal representatives, other healthcare providers or medical institution authority⁶. This way, all efforts are made to respect patients' autonomy.

Cases of informed consent decline, although not very common, are often encountered by surgeons⁷. However, once obtained, it is very rare that the patient will change his mind to decline a previously voluntary informed consent. What could lead to informed consent shift hasn't been fully explored because of the rareness of such a situation. A number of reasons may, however be responsible for such occurrences. For example, a surge in pre-operative anxiety and or stress, breach of trust by the surgeon or a feeling of incomplete understanding of the information provided.

In our case, the patient provided the initial informed consent following provision of detailed translation of the informed consent form. It is thus more likely a rise in pre-operative anxiety and or stress that triggered his change of mind while on the operating table. It however can't be undermined that the informed consent form only provided general information, and barely any procedure specific information such as the risks and overall outcome. This could have led to partial satisfaction despite initial consent. One limitation in this case was the absence of a psychologist or psychiatrist to assess the patient's mental status at the time of declining consent, which could have provided valuable insights into his decision-making. But the decision to delay surgery for the patient's emotional comfort reflects the healthcare team's commitment to respecting his wishes, even in a critical situation.

4. CONCLUSION

Informed consent is fundamental to medical ethics, in global surgery practice. The case of

this patient underscores the ethical complexities especially in emergency situations, in which balancing the urgency of life-saving interventions with patient autonomy can be exceptionally challenging. It therefore, serves as a poignant reminder of the ethical dilemmas healthcare providers may face in global surgery settings. Navigating such situations requires sensitivity, adaptability, and a commitment to respecting patient autonomy, even when time is of the essence. It also highlights the critical need for clear communication with patients and families regarding the risks and benefits of procedures and the importance of having advance directives or contingency plans in place. Use of procedure-specific consent form may foster acquisition and maintenance of informed consent in these situations.

5. RECOMMENDATIONS

We recommend continuous medical education sessions about such informed consent dilemma in addition to establishment and functionalization of ethical committees that can help navigate such challenges.

6. CONSENT

A written informed consent was sought from the patient's relatives to have this case written and published.

7. CONFLICT OF INTEREST

All authors of this work declare no conflicts of interest

8. ACKNOWLEDGMENTS

We acknowledge the dedicated healthcare team involved in caring for this patient and the patient's family during this challenging time.

9. AUTHORS' CONTRIBUTION

Eric Ssennuni: Conceptualization, Data Curation, Writing-Original draft, review and editing

Derrick Mukurasi: Conceptualization, Writing-Review and editing

Charles Mugweri: Conceptualization, Writing-Original draft, review and editing

Sarah Akello: Conceptualization, Writing-Original draft, review and editing

Martin D. Ogwang: Conceptualization, Writing-Review and editing

Ronald Okidi: Conceptualization, Writing-Review and editing

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Citation: Eric Ssennuni et al. Global Surgery Dilemmas: When Informed Consent Shifts - A Case Report of Gastric Perforation for Emergency Exploratory Laparotomy on Operating Table. *ARC Journal of Clinical Case Reports.* 2024; 10(1):19-22. DOI: <http://dx.doi.org/10.20431/2455-9806.1001004>.

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