

Putting the “No” in *Non Nocere*: Surgery, Anesthesia, and a Patient’s Right to Withdraw Consent

CLAUDINE YEE, BS; REBECCA S. HIMMELWRIGHT, BS; WALTER KLYCE, BA; TINA SANKHLA, MD; GEORGE P. BAYLISS, MD

THE CASE

Ms. K is a 53-year-old G2P1 with Stage IIIA endometrial cancer who presented to the Women & Infants ambulatory surgical unit for a bilateral salpingo-oophorectomy and lymph node dissection. In the pre-operative unit, a resident reviewed the standard informed consent protocol with the patient, outlining the reasons for the procedure, the risks and benefits of proceeding, and the risks and benefits of doing nothing. The resident emphasized the necessity of surgery to stage the cancer and prevent further spread. Ms. K appeared anxious, but signed the consent form. The anesthesia team then proceeded with their evaluation, determining that she had hypertension, type 2 diabetes, an anxiety disorder, a BMI of 58.2 kg/m² and a Mallampati Class IV airway difficult for intubation. The team thus decided to proceed with an awake intubation, using video laryngoscopy to visualize the larynx with minimal sedation to reduce the risk of airway collapse. Ms. K agreed to the plan.

The nursing staff then began preparing her for surgery, including inserting a peripheral IV for fluid and medication delivery. On the first failed attempt, Ms. K cringed. After the fourth unsuccessful needle stick, she became agitated and said, “I don’t want to do this anymore” multiple times. The crowd of IV nurses now assembled at her bedside reassured her and finally established access. The first medication through her IV was midazolam for mild sedation. She was then given pre-operative antacid but regurgitated half the solution. She was instructed to drink another cup, which she eventually swallowed through a steady stream of tears.

In the operating room (OR), the anesthesiologist began intubation. Despite the video camera attachment, the first few attempts were unsuccessful. She gagged multiple times and regurgitated fluid that obscured view of her airway. Over and over, she cried, “I don’t want to do this – I want to go home,” to which the anesthesiologist and nurses replied, “It’s ok, we’re almost there.” Finally, with a collective sigh of relief, the endotracheal tube was properly inserted. Medications for full sedation were administered and when the patient was fully sedated, the operation proceeded.

STUDENT ANALYSIS (CY, RH, WK)

This case involves a patient originally deemed to have full capacity who has consented to potentially life-extending surgery. In the process of preparing her for the operation, she expresses reluctance with continuing, to the point of

specifically asking that the procedure be aborted. Many ethics analyses center on the presence or absence of proper informed consent; fewer discuss withdrawal of consent.¹ However, the right to withdraw consent remains a standard component of every informed consent protocol.^{2,3,4} The UK Department of Health offers a useful paradigm for such situations: “A person with capacity is entitled to withdraw consent at any time, including during performance of a procedure. Where a person does object during treatment, it is good practice for the practitioner, if at all possible, to stop the procedure, establish the person’s concerns and explain the consequences of not completing the procedure.” It has in fact been deemed more than just “good practice” for the practitioner to stop the procedure – in a 2012 case, *Pallacovitch v. Waterbury Hospital*, the plaintiff sued on grounds of battery after her request to stop a blood draw was ignored.⁵ In this case, the patient’s initial refusal occurred before medications which might interfere with her capacity had been administered. At that moment, pausing preparations for the procedure would have been safe and possible from a medical standpoint. Presuming that this patient was indeed attempting to withdraw her consent, the team would have been violating her basic rights to autonomy and self-determination as well as opening themselves to medicolegal culpability.

The argument could be made that the patient did not have capacity to withdraw consent. Evidence that decision-making capacity is intact includes the ability to understand the current situation, use relevant information, and communicate preferences supported by reasons.⁶ The American Society of Anesthesiologists identifies groups of patients with “limited” decision-making capacity, including patients who can usually make decisions but whose decision-making capacity is temporarily altered. In these cases, physicians must use clinical judgment to determine a patient’s capacity, taking into account altering agents such as preoperative sedation and pain medication, as well as non-pharmacologic factors such as pain, panic, and shock. As previously mentioned, this patient’s initial refusal occurred before the administration of any medication. Perhaps, then, the clinical judgment of the team deemed that panic or pain diminished her decision-making capacity. However, should her mental state have been called into question, the team should have attempted to re-evaluate her capacity at that moment.⁷ This would involve a complete stop in the procedure to allow thorough reassessment of the patient’s understanding of her current situation and rationale regarding her desire to

withdraw consent. Without such an evaluation, a determination that she lacked capacity would be hard to defend.

In this case, all members of the health care team ignored the patient's requests to stop the procedure in favor of continuing as originally planned. That choice could have been made for a myriad of reasons: not wanting to waste time and resources spent on preparing the operation, reluctance to delay a busy OR schedule, or interpretation of her statements as an expression of pain rather than withdrawal of consent. However, continuing a procedure in light of such statements is in direct opposition to basic ethical principles of autonomy and decision-making capacity.

ETHICS COMMITTEE ANALYSIS #1 (TS)

This case presents an interesting, though unfortunately common, situation of a patient who consents for a procedure but then has second thoughts when she is experiencing physical discomfort. Considering usual practices and for the purposes of this analysis, we will assume that the patient was given a description of the operative plan and potential complications before signing the consent form. That said, no patient can ever be *fully informed* about what they may experience. Hearing a laundry list of possible complications and difficulties that "may" arise is a lot more palatable than actually experiencing the pain of multiple failed IV sticks, the nauseating taste of medication solutions, and the visceral discomfort of medical instruments being stuck down one's airway. The reality may end up being more than patients had initially thought they were agreeing to endure. Accordingly, while the pre-operative consent conversation is an important step in ensuring that we are respecting patient autonomy, we must also consider that a patient's wishes may change at any time and we must address their concerns as they arise.⁸

In this situation, when the patient verbalized "I don't want to do this anymore," taking the time to pause and address the patient's concerns would have been the best way to ensure respect of the patient's wishes if this could be done safely. This patient likely retained decision-making capacity at that point in time. Though the healthcare team was surely doing what they thought was in her best interest by continuing their attempts at starting an IV and later intubating the patient, ignoring her protests denied her the opportunity to be involved in decisions about her own care.

As the team may have assumed, it is very likely that the patient was just scared in those moments of discomfort and would have chosen to continue with the procedure if given the chance to have a discussion, but making this assumption without her input may risk a paternalism that undermines the patient's autonomy and ultimately her trust. Breaching autonomy could severely damage the doctor-patient relationship, discouraging her from seeking medical attention in the future and doing more harm than good in the long term. While the argument could be made that continuing the procedure was an act of beneficence by the healthcare

team, as the surgery was a vital component of her cancer treatment, it is not our place as healthcare providers to unilaterally make decisions on behalf of the patient, but rather to try to incorporate their values and ideals in shared decision making which is the basis for a strong doctor-patient relationship and improved healthcare outcomes.^{9,10}

Taking the time to address patient anxieties when trying to make progress with a procedure can be very frustrating, especially when facing a busy day's schedule and considering the expense of OR time. But if a patient of sound mind clearly and repeatedly states that she would like to stop, I think we are ethically obligated to at least hit pause.

ETHICS COMMITTEE ANALYSIS #2 (GB)

The vignette raises questions about autonomy, beneficence, non-maleficence. Was the patient's autonomy violated? The patient gave informed consent to both the surgical procedure and anesthesia. Informed consent involves providing the patient with information about the nature of the surgery, the expected benefits, possible risks and adverse events, alternative treatments to the surgery and consequences of not having the surgery.¹¹ It has become standard practice for anesthesiologists to consent patients for anesthesia with a separate consent process.¹²

Autonomy was preserved up until pre-operative discomfort made the patient cry out that she did not want to go through with surgery. The team may have assumed that this represented anxiety that would be overcome once the IV and endotracheal tube were in place and not an informed withdrawal of consent. But they did not assess that.

The principle of beneficence was upheld since the patient's chances of survival with the surgery seem greater than her chances without the surgery. Some authors have argued that beneficence should be seen as balancing the benefits against the risks.¹³ We do not know whether the surgical consent as outlined above described the risks and the consequences of not doing the surgery.

The need to do no harm was observed in this case. While some might see continuing despite her cries as *causing transient* distress, the overall harm of cancelling the surgery would far outweigh the harm caused by continuing despite her anxieties. Admittedly, an effort to assess the patient's fear ahead of surgery and the risk of surgery in the morbidly obese¹⁴ might have helped her understand and reduce her distress at the time of surgery.¹⁵

In summary, assessing the patient's anxiety as she was prepared for surgery may have allowed her more autonomy and reassured the team that it was justified in continuing with the procedure despite her initial protestations.

Acknowledgments

The authors thank Dr. Thomas Bledsoe for kickstarting this ambitious endeavor and lending his tireless support to every step of the process.

References

1. Gogoel MK, Miller JC, Rovelli L, Wassell SE, Forstie AM, Steen JO. Recent developments in medicine and the law. *Tort Trial & Insurance Practice Law Journal*. 2012;48(1):391-417.
2. Victorian Department of Health. *Informed Consent. Sector Performance, Quality and Rural Health*, Victorian Government, Department of Health. 2014.
3. Informed Consent. American Cancer Society. Accessed March 26, 2017. <https://www.cancer.org/treatment/finding-and-paying-for-treatment/understanding-financial-and-legal-matters/informed-consent.html>
4. Department of Health. *Reference guide to consent for examination of treatment*, second edition 2009. London: Department of Health, 2009;23.
5. Dooley KA. *Jo Ann Pallacovitch v. Waterbury Hospital*. FindLaw. Accessed March 26, 2017. <http://caselaw.findlaw.com/ct-superior-court/1610508.html>
6. Waisel DB, Truog RD. Informed Consent. *Anesthesiology: The Journal of the American Society of Anesthesiologists*. The American Society of Anesthesiologists, 01 Oct. 1997.
7. Gogoel MK, Miller JC, Rovelli L, Wassell SE, Forstie AM, Steen JO. Recent developments in medicine and the law. *Tort Trial & Insurance Practice Law Journal*. 2012;48(1):391-417.
8. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. 4th ed. New York, NY: Oxford University Press, 1994.
9. Chin JJ. Doctor-patient relationship: from medical paternalism to enhanced autonomy. *Singapore Medical Journal*. 2012;43(3):152-155.
10. Kelley JM, Kraft-Todd G, Schapira L, Kossowsky J, Riess H. The Influence of the Patient-Clinician Relationship on Healthcare Outcomes: A Systematic Review and Meta-Analysis of Randomized Controlled Trials. *PLoS ONE*. 2012;9(4):e94207. <https://doi.org/10.1371/journal.pone.0094207>
11. Hanson M, Pitt D. Informed consent for surgery: risk discussion and documentation. *Can J Surg*. 2017;60:69-70.
12. Marcucci C, Seagull FJ, Loreck D, Bourke DL, Sandson NB. Capacity to give surgical consent does not imply capacity to give anesthesia consent: implications for anesthesiologists. *Anesth Analg*. 2010;110:596-600.
13. Wall A, Angelos P, Brown D, Kodner IJ, Keune JD. Ethics in surgery. *Curr Probl Surg*. 2013;50:99-134.
14. Ogunnaike BO, Jones SB, Jones DB, Provost D, Whitten CW. Anesthetic considerations for bariatric surgery. *Anesth Analg*. 2002;95:1793-1805.
15. Boker A, Brownell L, Donen N. The Amsterdam preoperative anxiety and information scale provides a simple and reliable measure of preoperative anxiety. *Can J Anaesth*. 2002;49:792-798.

Authors

- Claudine Yee, BS; Warren Alpert Medical School of Brown University, Providence, RI.
- Rebecca S. Himmelwright, BS; Warren Alpert Medical School of Brown University, Providence, RI.
- Walter Klyce, BA; Warren Alpert Medical School of Brown University, Providence, RI.
- Tina Sankhla, MD; Warren Alpert Medical School of Brown University, Providence, RI.
- George P. Bayliss, MD; Associate Professor of Medicine, Warren Alpert Medical School of Brown University, Providence, RI.

Correspondence

Claudine Yee
Alpert Medical School of Brown University
222 Richmond Street
Providence, RI 02903
Claudine_Yee@brown.edu