Informed consent and sedation

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The concept of autonomy was not included in the Hippocratic Oath. Nowadays the principle of respect for autonomy is an important right. The basic paradigm of autonomy in health-care, politics and other contexts is expressed as informed consent. In the palliative-care setting, there can be some difficulties in getting informed consent, especially at the end-of-life stage. Can it be good for the patient, always? Could there be some exceptions? At the time of agonising pain, getting informed consent could become an additional burden for the patient. This present article attempts to shed light on this issue.

In our experience, it is not necessary to obtain written consent for a patient who has already expressed his priorities in advance. We believe that this is a good stance for patients as well as doctors.

Key words: informed consent, palliative sedation, end-of-life care.


The greatest misfortune that can befall a person is loss of health and awareness of disease. Further, if life is compromised then the patient is prey to intense anguish and discomfort. This is because the patient is not only organically affected but so is his psyche, his prospects of life, and his spirit, as well. Consideration and respect is what be deserves, and the ill patient needs to be supported with compassion in his misfortune with humanity, kindness and friendship. Before entering into greater detail, it is necessary to clarify some concepts such as ethics and morals. For «ethics» one needs only to invoke the origin of the word. In Greek «ethos» signifies «customary». Ethos, as stated by Aristotle, is the source which nurtures volition, the firm ground from which all human actions spring. It is not the same as «moral» which is the manner in which we behave, while ethics is the mental process by which we conduct ourselves i.e. moral is living and ethics is thinking. Socrates stated the essential philosophic concept of ethics: the distinction between good and evil. There is no consensus as to what is «good» for each one of us and at each moment in time. This uncertainty inevitably occurs at the moment of decision making in the final stage of life. We know that life is the greatest good in man. Supreme wisdom is reached when we are able to distinguish between doing good (beneficence) and doing wrong (malfeasance). The essence of the doctor consists in preserving the patient from damage and from injustice. Currently, moral concepts in medicine are being questioned due to the impact of recent events. Specialisation has fragmented medical knowledge and has transformed clinical practice. Institutionatisation of clinical practice has dehumanised interpersonal relationships. The principle of autonomy had not been contemplated within the Hippocratic Oath. The concept began in the 18th Century and was established definitively within juristic doctrine at the start of the 20th Century. It is a right that defines what must be done and what can be done by the doctor for his patient. Nevertheless, the phrase «I wish that...» by the patient need not be interpreted as an obligation to be fulfilled by the doctor. When autonomy is carried to extremes and with intent to convert it into an absolute principle without exceptions, it is conducive to aberrations, not the least of which is benevolent paternalism. Awareness of the rights of the patient in relation to the principle of autonomy, freedom of conscience, and moral pluralism makes it impossible to take decisions that have an underlying basis that is acceptable to all. The single code implied in the Hippocratic Oath (paternalistic relationship between doctor and patient) cannot be applied in current ethics. Other important factors contribute to the dismantling of the traditional concept of ethics in medicine. One factor is the politics of the free market and the legitimate right of all professionals to obtain the best benefits from their professional activity. Another factor can be termed «defensive medicine», in which clinical commitment is conservative because of fear of litigation for malpractice. The function of the doctor has widened and diversified and has become multiple faceted: scientist, businessman, executive, bureaucrat, expert on rights and legal procedures that regulate activity, guardian of civil rights and responsibili-
ties, administrator and economic regulator of social resources and, as well, the guardian of the interests of the patients and their needs. Clearly, the effect of all these imponderables has been to erode the idea of a common morality in medicine.

Over the past few years there has been a consolidation of the principle of patient autonomy. Informed decisions and the capacity for selection have increased considerably. This gives rise to new areas for the health-care professional, such as being able to communicate and to know how to provide relevant and comprehensible information that enables the patient to take a responsible decision. The most extreme situation is produced when there is the need to communicate «bad news»; a situation that is especially difficult when informing the patient on the prognosis of the disease that is very uncertain. This class of communication has an elevated emotional cost for all those involved, not only health-care professionals but also the patients.

Informed consent has a long history because it has arisen from the clash between the principle of autonomy and the traditional principle of beneficence, usually in the form of paternalism. All human beings have complete freedom to organise their own actions and to dispose of their personal properties voluntarily and by agreement, without their decisions depending on the desires of any other person. Can the individual be taught self-determination in relation to the authority of the health-care professional? This doubt has been in the forefront since 1957 when the concept of «informed consent» (IC) was used for the first time. IC has been converted into a fundamental element of the legal and ethical regulation of medicine.

In 1975, Spain slowly and progressively implemented the concept within the doctor-patient relationship which was mainly paternalistic. In 1986, Article 10 of the Health Directive recognised the need for written IC in specific situations in which the life or the health of the person was compromised.

The contract in medicine is for the hiring of services. The essential obligation on the part of the doctor is to provide the means, and not of outcomes. The obligation to determine what can be done with his own body. The freedom of choice is synonymous with the capacity to choose. However, to have the power to choose, it is a necessary pre-requisite that there is prior knowledge of the «menu» (information) available. Information provides empowerment, the power of choice and being able to exercise self-determination. In the analysis of the spread of choices, there are only two for the moribund patient: to end life with symptoms that have not been alleviated, or to die more comfortably.

In the first scenario, the long-term patient may have been in dialogue with the doctor and the decision will already be known, for example «Doctor, I wish to remain always aware throughout the process». In the second scenario, the patient will have offered sufficient direct or indirect indicators so that, at the final moment, we do not have to confront him with the hard decision, again. In both cases, death is dignified.