

FAST FACTS AND CONCEPTS #165
INFORMED CONSENT IN PALLIATIVE CARE – PART II

David E Weissman MD and Arthur Derse MD, JD

Background In *Fast Fact #164*, the legal basis for the informed consent process was reviewed; this *Fast Fact* discusses common myths about informed consent that arise in palliative care. Readers wishing more information should read the excellent review by Meisel and Kuczewski.

Myths:

- 1. Use of Signed Consent Forms—Myth:** *Federal or state laws require written informed consent (patient signature) for invasive procedures.* **FALSE:** The use of signed consent forms are used per local hospital or institutional or accrediting organization policies. They are generally not mandated by law or federal/state regulation. **Note:** state law may mandate written consent for certain tests or high risk treatment (e.g. HIV, genetic testing, or electroconvulsive therapy) and federal law may require written consent in some circumstances (e.g. transfers from emergency departments). Signed consent forms may not shield the physician from claims of negligence due to failure to provide informed consent if the physician did not fulfill the informed consent process (see *Fast Fact #164*).
- 2. Emergency Transport to a Medical Facility—Myth:** *No informed consent is necessary for patients admitted to a hospital in transfer from a nursing home, or for patients transported to the hospital following a 911 call.* **FALSE:** There is no “implied consent” just because 911 or a transport ambulance was called; such patients require the same level of informed consent discussions for medical care decisions as any other patient, unless the medical situation satisfies the criteria for the emergency exception (see *Fast Fact #164*).
- 3. Low Risk Treatments—Myth:** *No informed consent is necessary when starting “low risk” life sustaining treatments such as IV antibiotics, intravenous hydration, feeding-tube placement, or blood products.* **FALSE:** All these treatments represent interventions with risks and alternatives. An informed consent discussion is especially necessary in seriously ill or dying patients where the option of no intervention is a reasonable choice; *the failure to discuss not using life sustaining intervention represents a failure to provide full informed consent.* Also, patients should be informed that if a life sustaining treatment becomes too burdensome (a risk of any treatment), the patient may withdraw his or her consent and the treatment will be withdrawn.
- 4. Present options but not a recommendation—Myth:** *Informed consent means that patients should choose among medical option without physicians introducing their bias toward one specific option.* **FALSE:** The physician’s obligation is to present medical information accurately to the patient or to the individual responsible for the patient’s care and to make recommendations for management in accordance with good medical practice. The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives.
- 5. Documentation—Myth:** *An informed consent discussion needs no special documentation except in cases of invasive procedures.* **FALSE:** Even if not legally required, the content and outcome of an informed consent discussion should always be documented in the medical record and include the elements noted in *Fast Fact #164* as an indication that the ethical and legal requirements of the process of informed consent have been fulfilled.

References

1. Meisel A, Kuczewski. Legal and ethical myths about Informed Consent. *Arch Int Med.* 1996; 156:2521-2526.
2. Brett A, Rosenberg JC. The adequacy of informed consent for placement of gastrostomy tubes. *Arch Intern Med.* 2001; 161:745-748.
3. American Medical Association. *Informed Consent.* Available at: <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion808.page>.

4. American Medical Association. *AMA Position on Provision of Life-Sustaining Medical Treatment*. Available at: <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/about-ethics-group/ethics-resource-center/end-of-life-care/ama-policy-provision-life-sustaining-medical.shtml>.

Version History: This *Fast Fact* was originally edited by David E Weissman MD and published in October 2006. Version re-copy-edited in April 2009; then again July 2015: web-links updated.

Fast Facts and Concepts are edited by Sean Marks MD (Medical College of Wisconsin) and associate editor Drew A Rosielle MD (University of Minnesota Medical School), with the generous support of a volunteer peer-review editorial board, and are made available online by the [Palliative Care Network of Wisconsin](#) (PCNOW); the authors of each individual *Fast Fact* are solely responsible for that *Fast Fact's* content. The full set of *Fast Facts* are available at [Palliative Care Network of Wisconsin](#) with contact information, and how to reference *Fast Facts*.

Copyright: All *Fast Facts and Concepts* are published under a Creative Commons Attribution-NonCommercial 4.0 International Copyright (<http://creativecommons.org/licenses/by-nc/4.0/>). *Fast Facts* can only be copied and distributed for non-commercial, educational purposes. If you adapt or distribute a *Fast Fact*, let us know!

Disclaimer: *Fast Facts and Concepts* provide educational information for health care professionals. This information is not medical advice. *Fast Facts* are not continually updated, and new safety information may emerge after a *Fast Fact* is published. Health care providers should always exercise their own independent clinical judgment and consult other relevant and up-to-date experts and resources. Some *Fast Facts* cite the use of a product in a dosage, for an indication, or in a manner other than that recommended in the product labeling. Accordingly, the official prescribing information should be consulted before any such product is used.