Balancing Autonomy and Duty: Challenges of Managing Intraoperative Consent Revocation

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Introduction

Informed consent[1-3] obtained prior to a medical or surgical procedure signifies the patient's (or their surrogate's) permission to proceed.[1-7] The process of informed consent ideally includes a two-way discussion between the patient and clinician[3-6] about the procedure's components,[3,4] its individualized risks and benefits,[3,4] and value alignment for the "prudent"[a] patient.[4] This discussion should also cover alternative options, such as other surgical procedures, medical treatments, or therapies.[2-4,7,8] Additionally, the consent discussion should be in terms and language that can be understood by the patient.[4,6]

While informed consent may be commonly viewed as a single pre-procedure step or obtaining a signature on a form, it is not a one-time event. Instead, informed consent is an ongoing, collaborative process between the patient and clinician. Even after consent is initially given and the procedure begins, patients retain the right to withdraw consent.[9-12] This ongoing right to self-determination means that patients may elect to withdraw consent even after initiation of the procedure.

[a]Prudent refers to the medical and legal standard of informed consent that requires healthcare providers to ensure that informed consent includes sufficient information about a procedure that a "reasonable, prudent patient" would need to make a decision to consent to that procedure, focusing on what a reasonable patient would consider important to make this decision rather than what a provider deems necessary.[1,4]

Key considerations when a patient withdraws consent mid-procedure include:

- Does the patient have decision-making capacity?
- Is the patient under the influence of any medications or conditions, such as pain or fear, that may inhibit their ability and capacity to make high-quality decisions?
- Is the patient experiencing pain, anxiety, or fear that reflects inadequate provision of sedation and analgesia?
- Are the patient's protestations a manifestation of an acutely evolving crisis such as respiratory failure?
- Would stopping mid-procedure result in more harm to the patient(s) than proceeding?

In cases where a patient attempts to withdraw consent mid-procedure, clinicians face several clinical and ethical challenges balancing patient autonomy[2] with professional duty to avoid harm.[2,13] Key ethical considerations include: Does the patient have decision-making capacity?[11] Is the patient under the influence of any medications[10] or conditions, such as pain or fear, that may inhibit their ability and capacity to make high-quality decisions?[11] Is the patient experiencing pain, anxiety, or fear that reflects inadequate provision of sedation and analgesia? Are the patient's protestations a manifestation of an acutely evolving crisis such as respiratory failure? Would stopping mid-procedure result in more harm to the patient(s) than proceeding?[11] The context of such questions arising during a procedure adds additional time pressure threatening the adequate evaluation of these potential concerns. Therefore, consideration of these during pre-procedural preparations can avoid ethical and medical conflicts when they arise during interventions.

Many surgeries and procedures (e.g., awake craniotomy,[11,12,14] renal transplant,[15] cardiac catheterization,[16] cesarean section[17]) are performed while the patient is in a wakeful state, which reduces the risks associated with anesthesia and can improve the operation outcomes overall, but introduces a greater likelihood of patient interaction, including the potential for intraoperative consent withdrawal.[10-12,14] This article examines cases of intraoperative consent withdrawal and provides guidance on key considerations for determining whether to honor a patient's request to stop the procedure or override the patient's request to stop and proceed with necessary medical intervention.

Case Descriptions

The Patient Safety Authority (PSA) recently received a report submitted to the Pennsylvania Patient Safety Reporting System (PA-PSRS)[b;18] describing a case of intraoperative consent withdrawal that prompted a conversation about ethics surrounding this and other similar scenarios. The following case descriptions reflect scenarios informed by the PA-PSRS report, as well as other similar cases, to illustrate how patients withdraw consent mid-procedure and the ethical complexities clinicians face in these scenarios.

Case Description 1

A patient was undergoing cardiac catheterization under conscious sedation, an anesthetic strategy in which medications are administered to relieve procedural pain and anxiety that result in depressed mentation, while the patient remains responsive and ventilating independently. During the procedure, the patient was unable to lay still, expressed that they were in pain, and requested the procedure be stopped. Honoring the patient's wishes, the clinical team safely aborted the procedure. Shortly after stopping the procedure, the patient became unresponsive and subsequently died.

Case Description 2

A patient with acute kidney injury consented to a central venous catheter placement for urgent renal replacement therapy in the intensive care unit. The patient was undergoing an internal jugular dialysis catheter placement when they expressed discomfort with the positioning and draping. The team adjusted the drapes to reduce discomfort and reassured the patient. During the cutaneous dilation step of the procedure, the patient experienced additional discomfort and urged the clinicians to stop the procedure immediately. The clinical team declined to abort, proceeded with the remaining steps of the procedure, and successfully placed the dialysis catheter.

Case Description 3

A 32-year-old female who was 39 weeks pregnant presented to labor and delivery with spontaneous rupture of membranes. During an attempted vaginal delivery, the fetal monitor indicated signs of fetal distress, and clinicians determined that an emergency cesarean section was required to deliver the neonate safely. The patient consented to epidural catheter placement, which was completed before the cesarean became necessary. A separate consent for the cesarean was obtained before transfer to the operating room, but during the preoperative assessment a skin pinch test revealed the patient could feel the sensation of pain. She became visibly anxious and said she did not want to proceed with the surgery. Despite the obstetrician's explanation about the urgency of the situation and risk to the fetus, the patient continued to decline surgery due to fear of pain. The obstetrician and anesthesiologist conferred and made the decision to proceed with general anesthesia and perform the surgery. Neither the patient nor the infant had any identified medical complications after surgical delivery.

[b]PA-PSRS is a secure, web-based system through which Pennsylvania hospitals, ambulatory surgical facilities, abortion facilities, and birthing centers submit reports of patient safety–related incidents and serious events in accordance with mandatory reporting laws outlined in the Medical Care Availability and Reduction of Error (MCARE) Act (Act 13 of 2002). All reports submitted through PA-PSRS are confidential and no information about individual facilities or providers is made public.

Discussion

Ethical Considerations

Patient Right to Self-Determination and Informed Consent

The start of a procedure does not terminate a patient's right to self-determination.[11,12] The case descriptions outlined in this article present three scenarios in which clinicians used their best judgement to determine whether to honor a patient's request to stop a procedure or to continue against the patient's wishes. In each case, the clinicians were required to weigh their professional expertise with respect for patient autonomy and self-determination, while striving for the best possible outcome.

Once a procedure has begun, respecting a patient's right to self-determination[2] becomes more challenging. Patients may newly (and temporarily) lack the capacity[3,10] to make complex, high-risk decisions due to sedating medication,[10] fear, pain, anxiety,[11,14] positional discomfort,[14] or other procedural factors. Higher levels of risk, such as those conferred by aborting a procedure during critical stages, require higher levels of decision-making capacity. Time also becomes a factor when making decisions intraoperatively; rapidly reevaluating a patient's capacity to make such decisions may not be possible. Additionally, if clinicians determine a patient has sufficient capacity to make high-quality decisions,[2] engaging the patient in an informed discussion of updated risks and benefits in the context of stopping[11] mid-procedure may not be feasible.

The clinician must also consider whether the patient ever gave fully informed consent. A patient who requests to stop a procedure after it has begun may be reacting to unexpected intraoperative circumstances, such as pain,[19] that the patient did not understand or expect based on the initial consent discussion. While such distress may create bias that interferes with patients' abilities to make objective decisions about continuing the procedure, it also may indicate that the initial consent was not valid. Was adequate informed consent obtained pre-procedure if the patient was unprepared for what they experienced? How might pre-procedure informed consent and/or the procedural environment better help patients prepare and cope during procedures?

Clinician Duty to Avoid Harm and Promote Benefit

Clinicians have a duty to avoid harm,[2,13] act in the patient's best interest,[2] and promote patient well-being.[3,20] To this end, terminating a procedure due to patient request may lead to immediate harm to the patient, including risks that are directly related to procedure termination. Termination-associated risks likely would not be discussed with the patient during standard pre-procedural informed consent due to lack of anticipated intraoperative revocation of consent. Clinicians must assess the feasibility and safety of interruption to enact a new informed consent. In the absence of feasibility, the clinician must balance the patient's right to self-determination with their professional obligation to prevent harm.[11] In the example describing the cesarean section, clinicians also needed to consider the well-being of both the mother and fetus, as stopping mid-operation introduces risk to both.

If clinicians refuse to terminate the procedure upon patient request, in pursuit of protection from harm, patients may experience other forms of harm. Direct physical injuries may occur from an uncontrolled disruption of the procedure, for example, if the patient changes positions or reaches into the sterile field due to anxiety, discomfort, or frustration due to the procedure continuing against their wishes. Nonbodily harm that may result from continuing despite a patient's termination request includes medical trauma, erosion of trust in clinicians, and post-traumatic stress disorder.

Decision-Making Considerations and Implications for Surgical and Procedural Practice

The three case descriptions above highlight the nuanced, time-pressured decisions clinicians face when a patient's right to self-determination occurs within the context of intraoperative medical urgency. Each case highlights tensions between respecting patient autonomy, avoiding medical harm, and promoting patient well-being, all within the context of limited time and opportunity to engage in full capacity determination, collateral information gathering, reconsideration of relative risk, surrogate decision-making, and/or ethical analyses. In each case, clinicians chose to abort or proceed with a planned procedure with variable medical and unknown psychological outcomes for the patients. Clinicians also may experience distress in such circumstances, regardless of the decision they make and regardless of the medical outcomes.

Mitigating risks of intraoperative consent revocation may include identification of the critical step or steps of the procedure after which termination cannot safely occur, improved initial consent processes, and attention to the patient experience of the periprocedural period (**Table 1**). Clinicians should identify the point of no return for a given procedure in a particular patient, that is, the procedural step after which the procedure cannot be safely terminated. This should be based on increased risks to the patient from the procedure itself, such that the risk of harm to the patient prevents procedural cessation. Clinical agreement or even standardization of these critical steps for a given procedure would alleviate clinicians from the burden and pressure of navigating these determinations during a procedure.

Additionally, the consent process should include how the proceduralist will manage pain, anxiety, discomfort, or requests to stop or slow the procedure. For example, during a cesarean section, once the obstetrician makes the uterine incision the surgery must proceed as a continuous sequence of surgical steps through delivery and closure of the abdomen, to reduce the risk of maternal infection and safeguard the well-being of the fetus.[17]

Based on patterns of patient feedback, during the informed consent process, proceduralists may highlight specific portions of the procedure that patients often report as the most painful or distressing.[19,21] This may serve to align patient expectations with the procedural experience, authentically representing the risks of the procedure prior to its initiation. The consent process may also include necessary information about the point of no return, when available or relevant.[11,19] Finally, improved attention to patient psychological safety and physical comfort during the periprocedural period may augment trust in the clinical team, minimize distress, and avoid intraoperative panic.

Table 1. Decision-Making Considerations and Strategies to Address Mid-Procedure Revocation of Consent

Decision-Making Considerations	Strategies
Mitigate patient discomfort	• Change patient position, drapes, blankets, or other equipment • Use calming techniques, such as family presence or music during the procedure • Implement further pain management options or deeper sedation (e.g., general anesthesia)
Set realistic expectations for intraoperative discomfort	• During the informed consent discussion, set clear expectations about what the patient may experience (physically and mentally) during the procedure • Prior to the start of the procedure, make a plan to address any mid-procedure hesitation by the patient,[12] and explain this plan to the patient
Establish and maintain trust in the clinician	• Explain the patient's right to self-determination[21] before and throughout the procedure • Outline risks associated with stopping the procedure before it is completed[11] (e.g., clinical implications, patient disappointment, post-procedure termination)
Support the patient during the procedure	• Engage a multidisciplinary team[11] and have members attend to the patient if there is a high risk of discomfort or distress • Have a nonproceduralist available to support the patient with physical and emotional needs (separate from the technical aspects of the procedure)

Conclusion

Respecting patient autonomy during medical procedures requires a careful balance among honoring patient wishes and right to self-determination,[2,11,12,21] protecting patient safety, and avoiding harm.[2,13] Clinicians face ethical and practical challenges when a patient withdraws consent intraoperatively. When this occurs, clinicians must rapidly determine the decision-making capacity[3,10,11] of the patient, evaluate and weigh the relative risks versus benefits of stopping or continuing the procedure, and maintain procedural safety. Clear preoperative and intraoperative communication,[12,19,21] proactive mitigation of discomfort, and setting realistic expectations[19,21] are essential to building and preserving patient trust[1,3,6,7,21,22] and reducing intraoperative conflict.

Notes

Artificial intelligence (Copilot Chat) was used only to improve sentence clarity. No AI was used for generation of original content. The authors take full responsibility for the accuracy and integrity of the manuscript.

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References

1. Gillett GR. Informed Consent and Moral Integrity. *J Med Ethics*. 1989;15(3):117-23. doi:10.1136/jme.15.3.117

2. Wall A, Angelos P, Brown D, Kodner IJ, Keune JD. Ethics in Surgery. *Curr Probl Surg*. 2013;50(3):99-134. doi:10.1067/j.cpsurg.2012.11.004; PubMed PMID: 23445722

3. Sulmasy LS, Bledsoe TA. American College of Physicians Ethics Manual: Seventh Edition. *Ann Intern Med*. 2019;170(2_Suppl):S1-S32. doi:10.7326/M18-2160; PubMed PMID: 30641552

4. Kinnersley P, Phillips K, Savage K, et al. Interventions to Promote Informed Consent for Patients Undergoing Surgical and Other Invasive Healthcare Procedures. *Cochrane Database Syst Rev*. 2013;2013(7):CD009445. doi:10.1002/14651858.CD009445.pub2; PubMed PMID: 23832767; PubMed Central PMCID: PMCPMC11663509

5. Glaser J, Nouri S, Fernandez A, et al. Interventions to Improve Patient Comprehension in Informed Consent for Medical and Surgical Procedures: An Updated Systematic Review. *Med Decis Making*. 2020;40(2):119-43. doi:10.1177/0272989X19896348; PubMed PMID: 31948345; PubMed Central PMCID: PMCPMC7079202

6. The Joint Commission. Informed Consent: More Than Getting a Signature. *Quick Safety*. https://digitalassets.jointcommission.org/api/public/content/42fff32a10ff4f4399ed5d545b9a1994. Updated April 2022. Accessed January 2026.

7. *Medical Ethics Manual*. 3rd ed: World Medical Association; 2015.

8. Etchells E, Sharpe G, Walsh P, Williams JR, Singer PA. Bioethics for Clinicians: 1. Consent. *CMAJ*. 1996;155(2):177-80. PMID: 8800075; PMCID: PMC1487940

9. Feld AD. Informed Consent: Not Just for Procedures Anymore. *Am J Gastroenterol*. 2004;99(6):977-80. doi:10.1111/j.1572-0241.2004.40520.x; PubMed PMID: 15180712

10. Ward B, Shah S, Kirwan P, Mayberry JF. Issues of Consent in Colonoscopy: If a Patient Says "Stop" Should We Continue? *J R Soc Med*. 1999;92(3):132-3. doi:10.1177/014107689909200308

11. Ford PJ, Boulis NM, Montgomery Jr EB, Rezai AR. A Patient Revoking Consent During Awake Craniotomy: An Ethical Challenge. *Neuromodulation*. 2007;10(4):329-32. doi:10.1111/j.1525-1403.2007.00119.x

12. Kirsch B, Bernstein M. Ethical Challenges With Awake Craniotomy for Tumor. *Can J Neurol Sci*. 2012;39(1):78-82. doi:10.1017/s0317167100012737; PubMed PMID: 22384500

13. Tribble C, Julliard W. First, We Do Harm: Obtaining Informed Consent for Surgical Procedures. *Heart Surg Forum*. 2019;22(5):E423-E8. doi:10.1532/hsf.2743; PubMed PMID: 31596724

14. Herrick IA, Craen RA, Gelb AW, et al. Propofol Sedation During Awake Craniotomy for Seizures: Patient-Controlled Administration Versus Neurolept Analgesia. *Anesth Analg*. 1997;84(6):1285-91. doi:10.1097/00000539-199706000-00021

15. Garcia-Tomas V, Rohan V, Agrawal A, et al. Moving Toward Outpatient Kidney Transplantation: A Case Report. *Am J Transplant*. 2025;25(6):1350-3. doi:10.1016/j.ajt.2025.03.028; PubMed PMID: 40180184

16. Curzen N, Smith S. Consent in Cardiology: There May Be Trouble Ahead? *Heart*. 2005;91(7):977-80. doi:10.1136/hrt.2004.046698; PubMed PMID: 15958379; PubMed Central PMCID: PMCPMC1768974

17. Berghella V. Cesarean Birth: Surgical Technique. UpToDate. https://www.uptodate.com/contents/cesarean-birth-surgical-technique. Updated September 26, 2025. Accessed January 2026.

18. Pennsylvania Department of Health. Medical Care Availability and Reduction of Error (MCARE) Act, Pub. L. No. 154 Stat. 13 (2002). DOH website. https://www.pa.gov/content/dam/copapwp-pagov/en/health/documents/topics/documents/laws-and-regulations/Act%2013%20of%202002.pdf. Published 2002. Accessed January 2026.

19. Mallepally N, Bollipo S. Splenic Injury in Colonoscopy Prevention, Management & Malpractice Issues. *Gastroenterology and Endoscopic News*. 2023.

20. Pellegrino ED, Relman AS. Professional Medical Associations Ethical and Practical Guidelines. *JAMA*. 1999;282(10):984-6. doi: 10.1001/jama.282.10.984

21. Satyanarayana Rao KH. Informed Consent: An Ethical Obligation or Legal Compulsion? 2008;1(1):33-5. doi:10.4103/0974-2077.41159

22. Paterick TJ, Carson GV, Allen MC, Paterick TE. Medical Informed Consent: General Considerations for Physicians. *Mayo Clin Proc*. 2008;83(3):313-9. doi:10.4065/83.3.313; PubMed PMID: 18315998.

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