Clinicians’ Conscientious Objections to Provide Life Support to Patients with End Stage Illness

Douglas B. White, MD, MAS
Associate Professor of Critical Care Medicine
Director, Program on Ethics and Decision Making in Critical Illness

The CRISMA Center
Department of Critical Care Medicine
Center for Bioethics and Health Law
University of Pittsburgh School of Medicine
Disclosures

Research Funding

- NIH- National Institute on Aging
- NIH- National Heart, Lung, and Blood Institute
- Greenwall Foundation
Outline

- Explain the concept of conscience-based refusal (CBR).
- Highlight the distinction between refusals grounded in personal moral beliefs and those grounded in professional integrity.
- Explain why CBRs provide no new traction to unilaterally refuse to treat patients with advanced illness.
- Discuss the importance of institutional strategies to respect clinicians’ personal moral beliefs while ensuring patients receive legal, professionally accepted services.
Case

- Previously healthy 55 year old patient is admitted with large intracranial hemorrhage. Undergoes surgical evacuation, but is left with devastating neurologic injuries (MCS).

- Neurosurgeon informs family that life support will be withdrawn, saying that to do otherwise violates “what it means to respect the sanctity of human life.”
  - Family objects.
  - Physician: “You cannot force me to act against my conscience.”
Moral Concerns in ICUs

The relationship between moral distress and perception of futile care in the critical care unit

Melinda J. Mobley, Mohamed Y. Rady, Joseph L. Verheijde, Bhavesh Patel, Joel S. Larson

Moral Distress of Staff Nurses in a Medical Intensive Care Unit

By Ellen H. Eippern, RN, MSN, APN, CCNS, Barbara Covert, RN, BSN, CCRN, and Ruth Kleinpell, RN-CS, PhD, ACNP, CCRN. From Rush University Medical Center, Chicago, Ill.

Prevalence and Factors of Intensive Care Unit Conflicts

The Conflicus Study

Élie Azoulay, Jean-François Timsit, Charles L. Sprung, Marcio Soares, Kateřina Rusinová, Ariane Lafabrie, Ricardo Abizanda, Mia Svantesson, Francesca Rubulotta, Bara Ricou, Dominique Benoît, Daren Heyland, Gavin Joynt, Adrien François, Paulo Azevedo-Maia, Radoslaw Owczak, Julie Benbenishty, Michael de Vita, Andreas Valentin, Akos Ksomos, Simon Cohen, Lidija Kompan, Kwok Ho, Fekri Abroug, Anne Kaarloa, Herwig Gerlach, Theodoros Kyprianou, Andrej Michalsen, Sylvie Chevret, and Benoît Schlemmer, for the Conflicus Study Investigators and for the Ethics Section of the European Society of Intensive Care Medicine


the Clinical Research, Investigation, and Systems Modeling of Acute illness
What is a Conscience-Based Refusal (CBR)?

“A refusal to provide a legal, professionally accepted medical service based on a belief that providing the service would violate an individual’s core moral beliefs.”

Paradigmatic examples:
- To perform abortion
- To prescribe emergency contraception
- To participate in DCDD
- To participate in physician assisted suicide (where it is legal)

Wicclair M. Am J Bioethics; 2007
Controversy about the Relevance of Clinicians’ Moral Beliefs

“A doctor’s conscience has little place in the delivery of modern medical care. What should be provided to patients is defined by the law and consideration of just distribution of finite medical resources...If people are not prepared to offer legally permitted, beneficial care to a patient because it conflicts with their values, they should not be doctors.” (Savulescu J. BMJ 2006)

“Prohibition of coercion or derogation of the patient is a moral requisite. But there must be equal regard for the right of physicians to refuse. They must not be coerced by threats of loss of certification, or disciplinary action if they dissent from the mainline course.” (Pellegrino E. J Clin Ethics. 2008)
Reasons to Disallow CBRs

- Physicians have clear professional obligations:
  - To act **beneficently** toward their patients
  - To respect patients’ **right to self determination**
  - Voluntarily chose to enter the profession

- These duties are arguably higher in ICU setting
  - Patients are vulnerable
  - Patients cannot control choice of provider

- CBRs put physicians’ well-being in front of their professional duties to patients.
Reasons to Accommodate Clinicians’ CBRs

- No individual should be forced to participate in acts that violate their deeply held moral beliefs.
  - Moral integrity is highly valued
  - “Soul rape”

- To maintain quality of medical profession:
  - Prevent burnout
  - Foster diversity in profession
  - To encourage sensitivity to patients’ moral beliefs.

White DB. JAMA. 2011
Distinguishing CBRs from Other Reasons for Refusal

Other reasons to refuse to provide a treatment:

- Self interest (to avoid physical risk)
- Lack of professional competence
- Professional integrity: Violates accepted medical standards or laws
  - Illegal: Voluntary euthanasia
  - Treatments that cannot accomplish the goal
  - Socially agreed upon allocation strategies (organs, surgery)
The Purpose of CBRs

CBRs are meant to be “a shield, not a sword”.

- To protect an individual from being compelled to act against her conscience.
- Not to force one’s beliefs on others.

Individual clinicians’ moral beliefs lack authority to compel patients to receive/not receive treatment.

- Neurosurgeon oversteps this by seeking to bar patient from receiving ongoing ICU care.
- A pharmacist (who views OCPs as a form of abortion) refused not only to fill a prescription for birth-control pills but also refused to return the prescription to the patient or transfer it to another pharmacy.

Charo RA. NEJM. 2005
The Purpose of CBRs

“Claiming an unfettered right to autonomy while holding monopolistic control over a public utility (medicine) constitutes an abuse of the public trust - all the worse if it is not in fact a personal act of conscience but, rather, an attempt at cultural conquest.”

Charo RA. NEJM 2005
Why Is the Distinction Important?

CBRs provide less (rather than more) justification for unilateral action compared to refusals grounded in professional integrity.
## Distinction Between Refusals Based on Professional Integrity and CBRs

<table>
<thead>
<tr>
<th>Reason for Refusal</th>
<th>Source of Verification</th>
<th>Appropriate Action if Verified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violates boundaries of acceptable practice</td>
<td>Written rules, laws, peers</td>
<td>Refuse to provide treatment and do not aid in patient’s efforts to obtain the treatment.</td>
</tr>
<tr>
<td>Violates personal moral beliefs</td>
<td>Internal examination of moral beliefs</td>
<td>Seek accommodation to withdraw from a case</td>
</tr>
</tbody>
</table>
Conventional Compromise

CBRs should be accommodated if doing so does will not expose patient to serious harm.

Options
- Refer patient to another provider
- Complicity concern: arrange in advance to have a colleague refer to another provider.
  - Institutional management solutions.
The ICU Patient with Far Advanced Illness

- 91 year old man with advanced dementia and severe COPD admitted with respiratory failure and septic shock. No advance directive.
  - Prolonged ICU stay
  - Unresponsive with watershed infarcts
  - ARF, DIC
  - Necrotic extremities and pressure ulcers requiring serial debridement.

- Family insists on ongoing treatment.

- Nurses and physicians are deeply distressed.
  - “What we are doing is inhumane.”
  - “Against God”
Management Strategy

Clinicians object to providing life support

Is the requested treatment outside boundaries of accepted medical practice?

**YES:**
Do not provide tx.
Do not facilitate transfer.

**Professional Boundaries unclear:**
Use existing process based resolution mechanisms (e.g., AMA strategy)
* May also invoke CBR in interim

**NO:**
Seek exemption from case.
Provide treatment until alternate provider takes over care.
Mitigating Moral Distress

- **Institutional support services** (Rushton AACN Advanced Critical Care; 2006)

- **Harm minimization strategies**
  - Rotate nurses
  - Exempt those with the most intense moral objections

- Open discussions of morally controversial cases; seeking to create environment of tolerance and respect.
Clarifying Boundaries of Acceptable Medical Practice in Patients with Advanced illness

- Long term effort

- Will require
  - Genuine public engagement
  - Changing social expectations regarding what types of treatment they are entitled to near EOL.
Summary

- There is an important distinction between refusals to treat grounded in personal moral beliefs and those grounded in professional integrity.

- CBRs provide no new traction to unilaterally refuse treatment in patients with advanced illness.
  - Stronger ethical justification: the requested treatment is outside the boundaries of acceptable medical practice.

- CBRs should:
  - be accommodated whenever possible;
  - serve as a barometer for whether the descriptive standard of care is incongruous with the normative standard of care.