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CLINICAL UPDATE

Refusal to medical interventions☆

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Abstract Refusal to medical interventions is non-acceptance, voluntary and free, of an indicated medical intervention. What should the physician do in case of refusal? It is understandable that the rejection of a validated medical intervention is difficult to accept by the responsible physician when it raises the conflict of protection of life versus freedom of choice. Therefore it is important to follow some steps to incorporate the most relevant aspects of the conflict. These steps include: (1) giving complete information to patients, informing on possible alternatives, (2) determining whether the patient can decide (age, competency and level of capacity), (3) ascertaining whether the decision is free, (4) analyzing the decision with the patient, (5) persuading, (6) if the patient kept in the rejection decision, consider conscientious objection, (7) taking the decision based on the named criteria, and (8) finally, if the rejection is accepted, offer available alternatives.

PALABRAS CLAVE
Rechazo;
Toma de decisiones;
Libertad de elección

Rechazo a las actuaciones médicas

Resumen El rechazo a las actuaciones médicas es la no aceptación, voluntaria y libre, de una intervención médica indicada. ¿Qué debe hacer el médico ante el rechazo? Es comprensible que el rechazo a una actuación validada sea difícil de aceptar por el médico responsable cuando plantea el conflicto protección de la vida versus la libertad de elección. Por ello es importante seguir unos pasos que incorporen los aspectos más relevantes del conflicto. Estos pasos pueden ser: 1) dar información completa al paciente, informando sobre las posibles alternativas, 2) determinar si el paciente puede decidir (edad, capacidad legal y grado de competencia), 3) comprobar si la decisión es libre, 4) analizar la decisión con el paciente, 5) persuadirle, 6) si se mantiene en la decisión de rechazo, considerar la objeción de conciencia, 7) tomar la

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decisión en base a los criterios nombrados, 8) finalmente, si se acepta el rechazo, ofrecer las alternativas disponibles.

Clinical case

A 61-year-old man, a Jehovah's Witness, was admitted to a public hospital for fever, weight loss and hepatosplenomegaly. The patient presented pancytopenia (1000 leukocytes, hemoglobin 8.4 g/dL and a platelet count of 24,000 mm^{-3}) and hepatic impairment with coagulopathy. The results of the serology and blood cultures were negative. Broad-spectrum antibiotherapy and treatment with liposomal amphotericin B were initiated due to suspected leishmaniasis. The bone marrow aspirate showed reactive histiocytosis with signs of hemophagocytosis. The diagnosis was hemophagocytic syndrome. The clinicians proposed starting treatment with etoposide, cyclosporine and dexamethasone. Etoposide frequently causes thrombocytopenia. The patient and his family were informed about the high hemorrhagic risk and, with it, the need to transfuse blood products. The patient and his family rejected this option. The patient's ability to decide was preserved. He assumed the risk of rejecting the transfusions, which can lead to death, and accepted other measures. He provided the advance directive document and signed the refusal to consent to transfusions. As an alternative, erythropoietin was administered and the use of romiplostim was proposed. Romiplostim is a platelet production stimulator indicated for immune thrombocytopenic purpura, with no clinical evidence in hemophagocytic syndrome and a high financial cost (a 500-μg vial costs €2656). What approach should his physicians adopt?

Definition

The refusal of medical interventions is defined as the voluntary and free nonacceptance of an indicated diagnostic or therapeutic medical intervention. The refusal faithfully communicates the patient's innermost values, beliefs and wishes.[1,2]

It is important to differentiate the refusal of medical interventions from the limitation of therapeutic effort (LTE). LTE is proposed for patients with poor prognosis and/or poor quality of life and consists of not implementing certain measures that are considered disproportionate for the established therapeutic goal, mainly because they can cause more damage than actual benefit to the patient.[3] In recent years, other terms for LTE have been used (adjusting therapeutic efforts, restricting therapeutic intent); however, LTE continues to be widely used. An example of LTE would be not performing coronary angioplasty on a patient with end-stage disease who experiences an acute myocardial infarction, because the intervention in this case would not improve the general prognosis of the patient and risks injuring them. In the refusal of treatment, patients with an infarction have a good prognosis in which angioplasty represents the treatment of choice (the benefit clearly outweighs the potential risks); the patient, however, decided not to undergo the recommended intervention.

Ethical principal of refusal

The ethical principal of refusal lies in the obligation to respect the patient's freedom of choice, where they have the autonomy to decide, regardless of what is scientifically indicated. However, it is understandable that the responsible physician finds it difficult to accept the refusal of a test-based medical recommendation, because the clinician is witness to how the patient's decision can go against his physical wellbeing.[4] Therefore, for the responsible physician, the patient's decision to refuse represents a problem, because the physician cannot perform the option they consider optimal, and this can lead to a technical, ethical and, sometimes legal conflict.

The values that collide in the ethical conflict of refusal are, on one hand, the patient's freedom of choice and, on the other, their physical wellbeing (a fundamental element of health). This freedom versus health conflict is even greater when the reasons the patients put forth for the refusal are not, in the judgment of the practitioner, properly reasoned (because the patients' freedom can be questioned) or when the refusal can put the health of an organ in severe danger and can even threaten the patient's life. In these cases, the arguments for accepting the decision to refuse should be more concrete and well justified. This reasoning should be based on the complete autonomy of the patient to decide.[5]

Freedom of conscience started to be recognized with the liberal revolutions, starting in the 17th century. The first freedoms recognized in the West were those related to religion, followed by the freedom of conscience in the ideological and political fields. These first human rights were understood as basic, primary rights for all individuals as human beings. These rights were managed by the individual, without meddling by others or the government, and should be protected by Law.[6] The right to freedom of conscience has been extended to various settings, medicine being the last of these, possibly because health has been considered so important that it could only be managed by physicians. Finally, well into the 20th century, medicine has incorporated it de facto, thereby allowing patients to freely decide, even when physicians have other opinions. Thus it is laid down in the law.[7]

Legal basis of refusal of medical interventions

The first clear legal reference to refusal is possibly the verdict in the 1914 case of Schloendorff v. New York Hospital, which explicitly states that all patients have the right to individual inviolability, to choose how they wish to be treated medically, and that any intervention on their body