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# Treatment Over Objection—Moral Reasons for Reluctance

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Clinical ethics dilemmas often emerge at the intersection between the preferences of patients or their families and what physicians think best promotes patients' interests. The standard ethics guidance attempts to resolve these kinds of dilemmas by means of a 3-part stepwise progression of decision-making criteria. First, when patients possess "decision-making capacity"—when their treatment preferences reflect relatively sound reasoning and an understanding of their clinical situation—they are usually permitted to select suboptimal treatments.[1,2] Second, when patients are incapacitated, surrogates may make (suboptimal) decisions on their behalf. Third, in the absence of valid surrogates, physicians should treat patients who lack decision-making capacity in accordance with their best interests. But what about patients who lack decision-making capacity—perhaps because they do not reason well or because they poorly understand relevant medical facts—but who nonetheless have firm and consistent treatment preferences? What about patients who lack decision-making capacity but who possess what we have elsewhere called "capacity for preferences"?[3]

Treating patients over their objections can be morally distressing, regardless of patients' cognitive capacities.[4,5] However, the standard clinical ethics guidelines assert that only an autonomous patient's preferences matter morally; without such decisional capacity, the locus of decision making moves entirely to surrogates.[6] It follows that it is morally permissible to forcibly treat patients who lack decision-making capacity, even in the face of those patients' clear and consistent objections.[1]

What should we think of the fact that physicians are sometimes reluctant to treat patients over their objections, even when patients lack decisional capacity, surrogates assent, and treatments would promote patients' interests? Some may offer cynical explanations, but we argue that such reluctance can express well-founded moral intuitions and that clarifying the foundations of those intuitions can illuminate potential revisions to clinical ethics guidance. This is because the preferences of patients who lack decision-making capacity still matter morally. If the arguments we offer are correct, then we have identified an important lacuna in contemporary clinical ethical guidance.

Consider the following case:

A 63-year-old male patient is admitted for respiratory distress secondary to undifferentiated carcinoma, stage IIIB (5-year survival rate of 26%). The patient, who has trisomy 21 (Down syndrome), has lived in a group home since his parents died 10 years ago. He has a court-appointed guardian who makes medical decisions. The patient is a candidate for pulmonary lobectomy, but when the possibility of surgery is discussed with him, he repeatedly screams, "No, no, no!" He has been otherwise compliant during the current admission. The patient's guardian says she will authorize the surgery, but the thoracic surgeon refuses to take him as a patient, stating, "Even though I think surgery is the best option, I'm not going to operate on someone who is resisting like that."

According to the standard guidance, it would have been ethical for the surgeon to treat this patient, since doing so would have promoted the patient's best interests



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and would have been endorsed by his surrogate decision maker.[1,4] In this kind of case, treating over objection would not have violated the patient's autonomy because the patient was not autonomous, given his inability to make reasoned decisions. The surgeon also would be unlikely to have harmed the patient by treating him because the proposed treatment had a reasonable chance of a positive outcome. So, how could the physician justify his unwillingness to perform surgery?

Some explanations suggest that physicians' aversion to treating patients over objections are pragmatic or self-serving. For example:

(1) A patient's noncompliance could undermine the efficacy of treatment, eg, the patient may tear sutures or pull at a tracheostomy tube.
(2) Physicians may fear legal liability for engaging in forcible treatment if the patient recovers decision-making capacity (in cases of temporary or intermittent decisional impairment) or if surrogates reconsider their assent.
(3) It may be unpleasant for physicians to think of themselves, or be thought of by their team members, as ignoring the clearly expressed wishes of their patients, even if it is not morally objectionable to do so.

We suggest another explanation: Some physicians may feel, at least intuitively, that the preferences of patients who lack decision-making capacity have moral value, such that it is sometimes morally wrong to treat patients over their objections, even when treatment is consistent with their surrogate's preferences and even when treatment is likely to serve the best interests of the patient. If the standard guidance for clinical ethics is correct, then these physicians are making a mistake. But we think it is clinical ethics dogma that is mistaken (or at least underdeveloped).

First, taking a patient's preferences seriously is a requirement of treating a patient with the respect they are due as a person. Human beings who lack decision-making capacity are still persons from a moral point of view, and it is disrespectful to treat persons as bystanders or obstacles to their own care. In turn, when human beings express preferences, it is disrespectful to treat those utterances as morally irrelevant noise. Therefore, it is a requirement of respectfully treating decisionally incapacitated patients that physicians grant some moral weight to those patients' treatment preferences.

Second, treating a patient contrary to their preferences violates their liberty. People who lack decision-making capacity may nonetheless retain some liberty rights. Societies that cherish liberty routinely permit people to make important decisions—for example, about marriage, children, and careers—even when people reason poorly about those choices. In the absence of persuasive arguments to the contrary, there is little reason to think a citizen's liberty rights terminate at the hospital doors. Physicians who refuse to forcibly treat patients who lack decision-making capacity may be responding to a sense that such transgressions against liberty are not justified in the particular cases they are considering.

We agree that it is sometimes morally permissible to treat patients over their objections. Even though a patient's objection always counts against the treatment to which they object, reasons in favor of treatment can sometimes be more pressing. For example, treatment over objection in cases of potentially reversible psychosis may often be relatively unproblematic, from an ethical point of view.[4] However, when treatments are more invasive or when outcomes are less certain, arguments for the ethics of forcible treatment become less clear, since in those cases a patient's objection may carry comparatively more ethical weight. Importantly, the fact that forced treatment is at least sometimes morally permissible does not undermine our argument, according to which patient preferences always matter morally. Instead, the fact that an ethically justified instance of treatment over objection involves forcible treatment means that such acts always *have ethically regrettable aspects*,

even when they are all-things-considered ethically justified. Physicians, therefore, have good reason to consider whether they want to participate in the moral violations entailed by forcible treatment, even in service to justifiable ends and even if their patients' objections appear irrational or deluded.

We have elaborated on what we believe to be common moral intuitions that underpin the reluctance of some physicians to treat patients over objection. If our account is correct, we might wonder why other physicians are *not* reluctant to treat patients over objection. In response, it seems likely that some combination of unreflective habits of practice, legal permission (eg, from a guardian), and institutional ethics permission (eg, from a hospital ethics consultation service) can contribute to complacency about the ethics of treatment over objection. If these factors contribute to a pattern of disregard for the preferences of patients who lack decision-making capacity, then this is further reason to update clinical ethical guidance to take seriously the preferences of decisionally impaired patients.

It is worth reflecting on the fact that pediatrics has long embraced the idea that children who lack decision-making capacity have a moral claim to participate in deliberations about their treatment; this is the idea of "pediatric assent."[7] Indeed, one way to think about the arguments we make in this short article is that they extend the idea of pediatric assent to adult patients who lack decision-making capacity. Furthermore, although we applaud the American Academy of Pediatrics for its admirable efforts to support children's participation in decision making about their health care, we have argued elsewhere that the American Academy of Pediatrics' conception of pediatric assent can be better defended by directly addressing the moral value of patients' "capacity for preferences."[8] Like adults, children are worthy of respect, and their preferences matter morally, even when they do not reason well.

## CONCLUSION

Standard clinical ethics guidance directs physicians to protect their patients' autonomy and promote their interests. But these values cannot explain why physicians should take seriously the preferences of patients who lack decision-making capacity because these patients lack autonomy and they may refuse beneficial treatments. Instead, taking these patients' preferences seriously is a way to respect them as persons and to protect their liberty. Physicians' reluctance to treat patients over their objections may, therefore, reflect a well-founded moral intuition, rather than mere self-interest or pragmatism.

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