IS THIS A CASE OF REFUSAL OF TREATMENT?

CLINICAL CASE

Dr. Gómez is caring for Soledad, a patient who has been in the intensive care unit for the past three weeks. She was admitted due to respiratory septic shock. Unfortunately, her condition has not improved, and she remains dependent on invasive mechanical ventilation (IMV). In recent days, the medical team has informed her that she will likely require long-term mechanical ventilation. During periods of wakefulness, Soledad has clearly and consistently expressed her wish not to continue using the ventilator. In response, Dr. Gómez carefully assesses her understanding of the information provided and evaluates her decision-making capacity. He concludes that Soledad is making an informed, rational decision with full awareness of the consequences, and therefore considers her to be competent. Despite recognizing her competence, Dr. Gómez feels troubled by her decision. He discusses the case with a colleague, who argues that the limitation of therapeutic effort (LET) is ultimately a clinical decision and cannot be determined unilaterally by the patient. This perspective unsettles Dr. Gómez, as he had understood Soledad's refusal of ventilation as a rejection of treatment rather than an instance of LET. However, his colleague's comment raises an important question: Is this a case of treatment refusal, or does it fall under the framework of LET? Dr. Gómez now finds himself at a crossroads- should he respect Soledad's refusal of mechanical ventilation, recognizing her right to decline medical interventions? Or is the decision to withdraw or withhold life-sustaining treatment one that must ultimately be made by the medical team?

ETHICAL ANALYSIS OF THE CASE

A patient's refusal of a medical procedure represents their decision to decline a diagnostic or therapeutic intervention that is deemed beneficial and medically indicated. The core ethical conflict in such cases arises from the tension between the patient's autonomy and the healthcare provider's duty of care. For a refusal to be ethically and legally valid, the patient must be fully informed, demonstrate decision-making competence, and their refusal must not pose a significant risk to third parties. This last criterion is why vaccine refusal remains so controversial—because an individual's choice can have negative repercussions for public health.

Typically, a patient's refusal applies to a specific medical intervention at a particular moment in time. It is not necessarily a wholesale rejection of all treatment but rather a refusal of a specific procedure, such as surgery, chemotherapy, or hospital admission. When a patient declines a clearly beneficial treatment, healthcare providers may experience frustration. This reaction stems both from concern that the refusal could seriously harm—or even lead to the death of—the patient and from a sense that their medical judgment is being disregarded.
It is important to distinguish between treatment refusal and the limitation of therapeutic effort (LET). LET involves withholding or withdrawing medical interventions (diagnostic or therapeutic)

in patients at the end of life when such interventions are no longer beneficial and may even cause harm. In LET, the decision is based on the assessment that the procedure is no longer indicated because its burdens outweigh its benefits. In contrast, treatment refusal involves a patient rejecting an intervention that remains medically indicated and could improve their condition

In the case at hand, the ethical dilemma revolves around whether this is a case of treatment refusal—in which a patient is choosing to forgo an intervention that could still provide benefit—or a case of LET, where mechanical ventilation is no longer offering meaningful benefit and its continuation would be considered disproportionate.

POSSIBLE COURSES OF ACTION

- Report the case to the appropriate judicial authority, allowing the court to determine what is in the patient's best interest.
- Obtain consent through a surrogate decision-maker, relying on the patient's family to guide the decision.
- Present the case in a formal clinical ethics or multidisciplinary team meeting to assess whether mechanical ventilation continues to provide clinical benefit.
- Evaluate whether the patient has been given complete and comprehensible information about the risks and benefits of withdrawing mechanical ventilation. If necessary, improve communication to ensure the patient fully understands the potential consequences of their decision
- Engage in a process of recommendation-based persuasion, in which the physician provides guidance while respecting the patient's final decision.
- Conduct another assessment of the patient's decision-making capacity. If uncertainty remains, seek consultation from a psychiatrist to formally determine whether the patient is competent to make this decision.
- Discontinue all life-sustaining treatments and interventions, in accordance with their expressed wishes..
- If mechanical ventilation is withdrawn, explain to the patient that palliative sedation would be advisable to prevent distress, as the absence of ventilatory support could lead to severe respiratory insufficiency and suffering.

RECOMMENDED COURSE OF ACTION

- The first step in addressing this case is to clarify whether it constitutes treatment refusal or limitation of therapeutic effort (LET), as each scenario requires a different approach. Based on the limited information available, this situation appears to be a case of treatment refusal, given that there is no clear evidence that mechanical ventilation has become disproportionate, that the patient is in a state of refractory illness, or that the medical team considers ventilation to be futile (i.e., providing no meaningful benefit). However, to ensure a thorough assessment, it would be prudent to present the case in a clinical team meeting to evaluate whether IMV continues to provide clinical benefit.

- Given the serious consequences of refusing treatment, it is crucial to reconfirm that the patient's decision is informed, voluntary, and autonomous—which means reassessing her competence. This requires optimizing the way information is communicated and, if necessary, re-evaluating her decision-making capacity. Importantly, the process of informing the patient should not be a one-way exchange; it should involve actively listening to her concerns and exploring the underlying reasons for her refusal. This may help identify whether any of her concerns are addressable, potentially altering her decision.
- If it is determined that the patient is competent, the physician should strongly recommend the course of action that is in her best medical interest (continuing mechanical ventilation) while ensuring she fully understands the consequences of rejecting this intervention.
- If the patient remains steadfast in her decision after being fully informed and evaluated, her choice must be respected. Since her refusal is not an absolute rejection of all medical care, but rather a specific refusal of mechanical ventilation, the healthcare team must offer her the best possible alternative treatments. In this case, the most appropriate course would be palliative management of respiratory insufficiency, which may include palliative sedation to prevent suffering as ventilation is withdrawn.

DISCUSSION

In medical decision-making, patients must receive comprehensive information about any proposed procedure, and their decision must be made competently and autonomously, without coercion from third parties. When these criteria are met—ensuring that the decision is voluntary and informed—a fundamental principle of informed consent is that the patient retains the right to refuse the proposed treatment. In such cases, provided that the decision is not being made through a surrogate or proxy, the physician is ethically and legally bound to respect the patient's choice, even if it is not in the patient's best medical interest. This obligation holds true even when the refusal may lead to the patient's death.

The gravity of a decision that could result in a patient's death adds significant complexity for the physician. It is not uncommon for healthcare providers to misinterpret treatment refusal as LET or to conflate it with other end-of-life concepts, such as euthanasia or physician-assisted suicide. However, it is critical to distinguish these terms: and regardless patient abandonment must be avoided. Even when a patient refuses a life-sustaining intervention, the physician's responsibility remains—to seek and provide the best alternative options.

Finally, it is important that physicians understand these different concepts and their clinical applications, as this knowledge will assist them in the decision-making process. Ensuring that medical professionals are well-versed in these frameworks should be an integral part of their academic and practical training.

Sgd.: Committee on Bioethics and Health Law of ASISA-Lavinia
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