International Journal of Gynecology and Obstetrics 128 (2015) 280–281

Contents lists available at ScienceDirect

International Journal of Gynecology and Obstetrics

journal homepage: www.elsevier.com/locate/ijgo

FIGO COMMITTEE REPORT

Patients' refusal of recommended treatment

FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health

The FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health considers the ethical aspects of issues that impact the discipline of obstetrics, gynecology, and women's health. The following document represents the result of that carefully researched and considered discussion. This material is intended to provide material for consideration and debate about these ethical aspects of our discipline for member organizations and their constituent membership.

B. Dickens, Chair
FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health
E-mail: figo@figo.org
Website: www.figo.org

Bernard Dickens
University of Toronto
Faculty of Law
84 Queen's Park
Toronto M5S 2C5, Canada
Tel: +1 416 978 4849
Fax: +1 416 978 7899
E-mail: bernard.dickens@utoronto.ca

Background

1. Treatment may ethically be provided to patients only with their informed consent. It follows that, if they refuse consent to recommended treatments, such treatments usually cannot ethically be imposed upon them. The clinical management of patients' refusals of recommended treatment raises ethical concerns regarding informed refusal, patients' mental and legal capacity to make their decisions, and whether refusals may be overridden by, for instance, parental or other authority, or courts of law.
2. No third party can forbid recommended treatment on behalf of a competent adult or adolescent patient who gives consent to it, and anyone legally required to meet the costs of the patient's necessary care who has the means to pay but refuses may face legal liability for failure to provide care necessary to life.
3. Refusals may be, for instance, of blood transfusion or the use of blood products such as albumin, and be based on religious, cultural, philosophical, or other convictions. Even when based on apparently irrational, mistaken, or confused grounds, however, refusals warrant respect, and in law, imposing treatment contrary to patients' refusals, whatever their basis, is likely to constitute a civil (non-criminal) wrong such as assault, and even a crime.
4. Patients may refuse recommended treatment at the time when it is offered, and may also prepare advance directives that show what medical treatments they intend in the future to accept or refuse, and/or who is to make and/or express choices on their behalf when they are incapable of forming and/or expressing their wishes. Such advance directives may be general refusals for instance of blood transfusion and blood-derived products, but advance directives based on legislation often focus on end-of-life care. Advance directives may similarly apply, however, in gynecology and obstetrics when patients face, for instance, childbirth involving episiotomy or heavy blood loss, or gynecologic surgery under anesthetic.
5. Patients must ethically be offered appropriate information to make their medical decisions. The ethical purpose of informing patients is not to induce their consent, but to aid informed decisions. Patients may freely decline this offer, and consent to recommended treatments by trusting their physicians without further explanation. If they refuse indicated treatment recommended to them in their best interests, however, providers must ensure that they understand why it is recommended, and the implications for their health of forgoing treatment or having alternative treatment. Providers must also ensure that patients understand the implications of their decisions for others for whom they care, such as their dependent and/or future children.
6. Patients who refuse recommended treatments but voluntarily maintain their doctor–patient relationships cannot be abandoned. Every effort must be made to provide alternative care acceptable to the individual patient that meets professional standards. This may include, for instance, surgery without blood transfusion, use of synthetic blood substitutes, or when feasible and acceptable to patients, recovery and reinfusion of their own blood. Patients who refuse cesarean deliveries must be assisted in natural delivery. Providers commit no ethical or legal breach in complying with informed patients' freely chosen refusals of recommended care, even when the patients' lives are in peril.
7. Patients' refusals of recommended treatments may raise issues of patients' decision-making capacity. Mental incapacity is often stigmatizing, and should not be presumed from refusals. Patients may be asked their reasons for refusing recommended treatments,

http://dx.doi.org/10.1016/j.ijgo.2014.10.009
0020-7292/

to determine whether their refusals are based on misunderstandings that may be corrected. However, patients cannot be compelled to give reasons for their refusals, and even those that appear emotional and irrational or neurotic are ethically and legally binding. Mature adolescents' refusals cannot ethically be overridden by parental authority (See FIGO recommendations on "Adolescent and youth reproductive health care and confidentiality"). Treatment cannot usually be imposed even when patients' reasons for refusal disclose more serious mental disorders, bordering on psychosis, but any legally empowered substitute decision-makers should then be sought in preference to requesting judicial decisions on patients' mental competency.

8. As an exception to the informed consent requirements above, in emergency situations where consent cannot be obtained from or on behalf of the patient or by court authorization and there is no knowledge of the patient's preferences, emergency treatment should proceed based on reasonably implied consent. Further, in emergencies when patients' lives or continuing health are in immediate danger, such as during childbirth, treatment may be given even contrary to previous agreements, but this is not ethically obligatory. Any proposed exceptional treatment without court approval, on the presumption of patients' reasonably implied consent, or that overrides a refusal of treatment, should be subject to prior independent review of its medical necessity or, when prior review is not possible, prompt independent subsequent review.
9. It is permissible to request patients in advance to absolve providers from legal liability for compliance with their informed refusals of recommended treatments. However, care appropriate in the circumstances cannot ethically be denied simply because patients decline requests for providers' release from legal liability for compliance with patients' refusals. Patients' informed acceptance of the risks of forgoing indicated care precludes providers' legal liability for reasonably foreseeable consequences (see 6 above).
10. The discussion of ethical approaches above is applicable in principle to patients' refusals of elective diagnostic tests, for instance conducted on their tissue or other samples.
11. Providers whose patients refuse their recommendations for care may refer them for additional opinion if desired by the patients or, preferably with the patients' consent, refer them to other accessible providers in their own departments or facilities, or in other facilities, provided that they ensure continuity of patients' care.

Recommendations

1. Practitioners should explain to their patients why they recommend particular treatments in terms their patients can understand, but accept their patients' rights to informed refusal.
2. Practitioners should offer to inform refusing patients about the implications for their health of failure to undergo recommended treatments, about available alternative treatments, and their prognoses if they withdraw from undertaking any treatment.
3. Practitioners should not presume that a patient's refusal of recommended treatment is due to the patient's intellectual failure to understand why it is recommended.
4. Intellectually mature minors' decisions to refuse or consent to recommended treatments should not be allowed to be overridden by parents' or guardians' preferences.
5. If, after appropriate testing, patients seem to lack intellectual capacity to make treatment decisions for themselves, practitioners should enquire whether patients have designated other persons, such as family members, to express or make medical treatment decisions for them.
6. If there continues to be concern over the patient's capacity to make treatment decisions, and no substitute decision-maker is identified or gives consent, the discretion to seek judicial approval to override a refusal of recommended treatment by, or on behalf of, a patient should be exercised only if consultation shows the patient's life or continuing health to be at serious risk.
7. If a patient lacks capacity and a substitute decision-maker is unavailable or a judicial application is not feasible, any treatment overriding the patient's refusal should be considered only in an emergency endangering the patient's life or continuing health, and preceded, or if this is not possible then followed, by an independent review.
8. No third party should be allowed to refuse administration of necessary treatment to which a mentally competent patient consents.
9. A provider whose patient refuses recommended treatment may transfer responsibility for the patient's further care to another suitable provider, on the condition that continuity of patient care is maintained.

London, March 2014