Logical, Reasonable, Consistent: Should we accommodate doctors' conscientious objections to treatment in the NICU?

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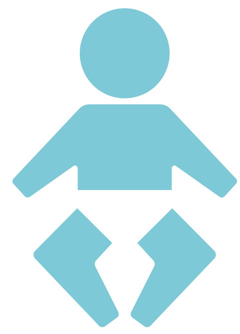
BACKGROUND

Outcomes in the NICU are uncertain, and treatment is often painful and expensive. Sometimes it is unclear whether providing treatment is in an infant's best interests.



Baby A:
- 23w3d gestation
- Bilateral IVHs (L grade III, R grade IV)
- Necrotising enterocolitis

Doctor Y is asked to insert an arterial line for Baby A's treatment. The smallest cannula is longer than the infant's shin. Doctor Y is skilful, but the procedure is ***lengthy and painful****. He is ultimately unsuccessful.*

NICU treatment represents a ***significant burden*** *for Baby A, and it is unclear if he will survive, even with treatment. Doctor Y feels that further attempts are against the infant's* ***best interests****. He is unwilling to perform similar procedures for infants with such poor prognosis.*

- *12% of 23 week infants survive to discharge without death or major morbidity(1).*
- *Grade III IVH risk of abnormal motor development = ~25%; grade IV = ~50%(2).*
- *20 - 30% mortality for infants with NEC(3).*
- *Infants in the NICU undergo around 100 painful procedures a week(4).*

AFFILIATIONS
1: University of Melbourne
2: University of Oxford
3: John Radcliffe Hospital

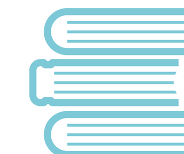
Would it be permissible for Doctor Y to conscientiously object to treatment that he regards as potentially inappropriate?

AIMS & OBJECTIVES

- **To survey published literature on doctors' conscientious objection to treatment provision in the NICU**
- **To propose and defend a system for assessing the justifiability of healthcare providers' conscientious objections**

METHODS

A PubMed Search was performed using MeSH search headings.



The search string yielded 265 articles.

Papers were screened by:
- English language
- relevancy
- publication date
- availability of full text

Box 1: MeSH Headings

Withholding treatment **OR** Refusal to treat **OR** Conscientious refusal to treat

AND

Infant, newborn (Abnormalities, nursing, mortality) **OR** Infant, premature **OR** Infant low birthweight

Further relevant papers were selected from citations, references, and supervisor recommendations, widening the inclusion of relevant literature.

Of the 141 articles selected, only 6 explicitly discussed conscientious objection.

RESULTS

Conscientious Objection

Refusal to provide ***legal, professionally-sanctioned*** *treatment because doing so would* ***contradict*** *deeply held* ***moral convictions****(5).*

Why accommodate Conscientious Objection?

- Acknowledging genuine moral uncertainty
- Respecting other value systems
- Preserving physician integrity
- Respecting professional autonomy

Best Interests and Moral Uncertainty

Defining best interests is difficult, because it is hard to list all the things that make a good human life:

self-determination

meaningful relationships

ability to learn and experience pleasure

freedom from pain

ability to communicate

parental factors and preferences*

*impact on siblings**

*best interests of the family**

An assessment of best interests evaluates the infant's likely experience with and without treatment.

Why not?

- Privileges physician's values over patient's
- Discounts patients' right to access legal, professionally-sanctioned treatment
- Creates unjustified variability in access to treatment

**Some accounts include these when determining an infant's best interests because families' attitudes and ability to care for their children can significantly affect an infant's quality of life(6).*

Objections arising from Best Interests

Judgements of best interests are value judgements, because there is no universal threshold for when it becomes in one's best interests to die. In cases with significant moral uncertainty, treatment and non-treatment may both be reasonable options.

Refusals to provide treatment arising from concerns for best interests could represent conscientious objection, if:

- **the refusal was motivated by a sincerely-held belief that the action would be wrong**

AND

- **the request was a medically reasonable course of action**

How small a chance?: *With a 1% chance of survival, doctors will harm ninety-nine infants with futile treatments to save the life of one.*

PROPOSALS

Doctors should object only when the infant's prognosis is far from the doctor's threshold for Best Interests

The worse an infant's prognosis, the more likely a treatment represents a net harm - justifying the objection.

Fig 1: Prognostic assessments are subject to **significant uncertainty**. An infant close to the threshold of acceptability **may fall within a doctor's zone of acceptability.**

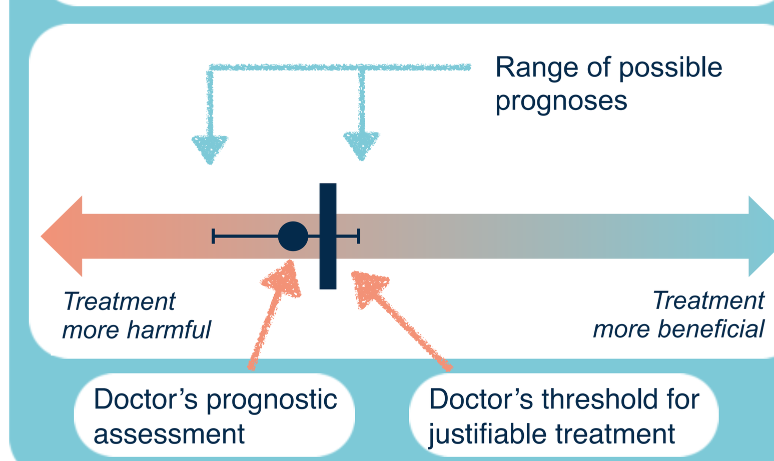
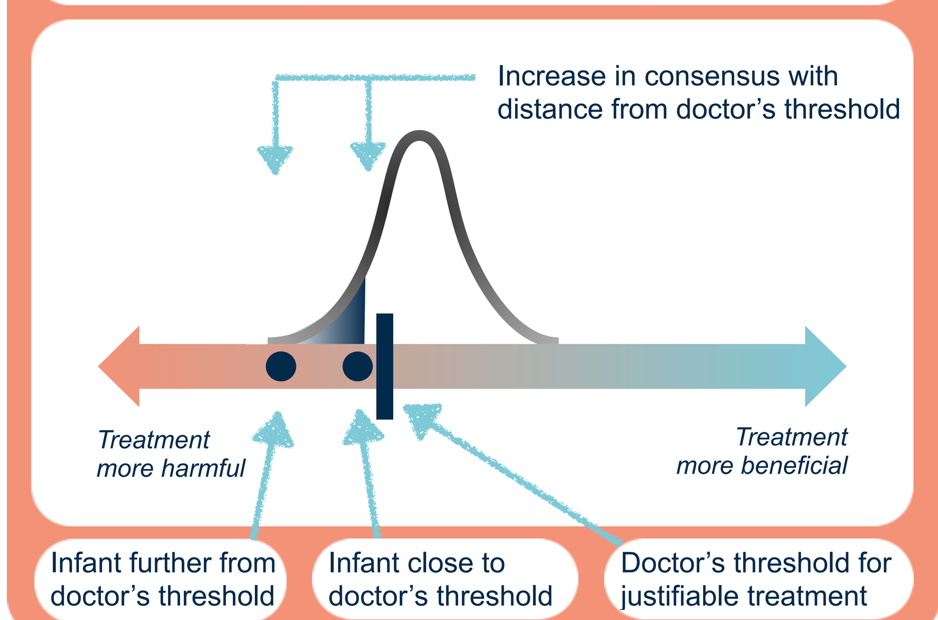


Fig 2: Doctors have **differing thresholds** for an acceptable balance of harms and benefits. The **worse an infant's prognosis**, or the smaller the benefit from treatment, **the more other doctors will support** the first doctor's objection.



Hospitals ought to accommodate conscientious objections which are logical, consistent and reasonable.

CONCLUSIONS

Accommodating conscientious objections is a balance between acknowledging genuine moral uncertainty and preventing unjustified variability in treatment access.

Assessments of best interests are value judgements, and thus refusals to treat arising from concerns for best interests could represent conscientious objections.

Accommodating only logical, consistent and reasonable objections minimises unjustified variability in treatment access.

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