CONSCIENTIOUS OBJECTION IN THE HEALING PROFESSIONS:

A READER'S GUIDE TO THE ETHICAL AND SOCIAL ISSUES

End-of-life Care

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In the United States, one out of five Americans dies during hospitalization in an intensive care unit (ICU), with 90% of these deaths resulting from a decision to withhold or withdraw life support.[1,2] As medical technology becomes more advanced, decisions to withhold, withdraw, or utilize life support and other medical technologies that have the ability to keep individuals alive have blurred the line between what constitutes imperative life sustaining treatment, and optional extraordinary measures.

Respect for patient autonomy includes efforts to provide patients with greater agency in end-of-life care decisions. This fact, however, does not preclude conflicts between patients, families and healthcare providers. In this regard, the Karen Quinlan case remains a key milestone in the legal and cultural debates about end-of-life care.[3] Quinlan entered a persistent vegetative state in 1975. In 1976, the New Jersey Supreme Court granted Quinlan's parents the power to decide when to refuse life sustaining treatments for their daughter.[4] This case was followed by other widely debated "right to die" and end-of-life disputes. These disputes included the cases of Nancy Cruzan (1983) and Theresa Schiavo (1990).[3] These cases resulted in prolonged legal disputes and have changed how patients are advised to plan for the end of life.[5–8]

Although patients are now afforded the autonomy to decide when they want (or no longer want) to be treated, this does not preclude physicians from conscientiously objecting to a patient's request. This is an important distinction to make because a physician's conscientious objection to a patient's autonomous end-of-life care decision could render the patient's autonomous decision moot if there is not another physician on hand willing to abide by the patient's request. For example, if a patient wished to legally end his life through physician assisted death (in a state where this is legal; e.g., Montana, Oregon, Vermont, and Washington), his physician could conscientiously object to fulfilling the patient's wish.[9] Although the patient might have a legal and ethical right to request his life be ended, his wish would not be fulfilled if a non-objecting physicians were not available to assist.

The Patient Self-Determination Act (PSDA) is currently the only federal legislation that pertains to end-of-life decisions.[7] The PSDA requires all health care providers who receive Medicaid and

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Medicare reimbursements to ask patients upon admission if they have an advance directive, and if not, whether they would like to speak to someone about making one. Although the PSDA requires providers to ask patients if they have an advance directive, there is no law requiring physicians, surrogate decision makers, and patients to utilize advance directives during end-of-life decision making. While the Quinlan case is generally accepted as the precedent for granting patients autonomy in making end-of-life decisions, there is no federal law (at this date) defining the exact expectations for physicians.

In November 2009 U.S. Conference of Catholic Bishops revised Directive 58 of the *Ethical and Religious Directives for Catholic Health Care Services*.[10] The revision emphasized the role of conscientious objection during end-of-life decisions and brought the topic into wide public debate. According to the directive, Catholic health facilities have "an obligation to provide patients with . . . medically assisted nutrition and hydration" regardless of whether they are in "chronic and presumably irreversible conditions."[10] Although the hospital policy may be to provide medically assisted nutrition and hydration to patients, not all physicians find it humane to prolong inevitable death with artificial hydration and nutrition because it extends suffering by preventing the patient from dying a "natural" death.[11] The U.S. Bishops' directive that health facilities provide patients with nutrition and hydration, therefore, may result in some healthcare providers objecting to care decisions on both sides of the issue.

Given the lack of federal guidance, each state has individually defined standards for how to handle end-of-life decisions.[12] In many states, physicians are explicitly given the option to object to an individual's instruction or health care decision for reasons of conscience; however, not all states have addressed how to address conflicts of conscience during end-of-life care decisions.

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