EthxWeb Search Results

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Document 1
Naunheim, Keith S; Bridges, Charles R; Sade, Robert M
Should a Jehovah’s Witness patient who faces imminent exsanguination be transfused?
The Annals of thoracic surgery 2011 Nov; 92(5): 1559-64
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Document 2
Panico, Megan L; Jenq, Grace Y; Brewster, Ursula C
When a patient refuses life-saving care: issues raised when treating a Jehovah’s Witness.
Abstract: Patients who are Jehovah's Witnesses frequently cross the path of nephrologists when they are acutely ill in the intensive care unit and stable in the long-term setting. It is important that we as a group have a rudimentary understanding of their philosophy about blood transfusion so that we can be proactive in their management. We use a case as a launching point to discuss the origins of the faith and the decision to refuse blood, as well as potential therapeutic strategies that can be used to improve the care of these patients. Improvement in our understanding as physicians will facilitate a more productive conversation with our patients about a complex and emotional issue.
Georgetown users check Georgetown Journal Finder for access to full text

Document 3
Owiti, J A; Bowers, L
A narrative review of studies of refusal of psychotropic medication in acute inpatient psychiatric care.
Journal of psychiatric and mental health nursing 2011 Sep; 18(7): 637-47
Abstract: This paper offers a narrative review of the 22 studies of medication refusal in acute psychiatry. Because of varied definitions of medication refusal, diverse methodologies and few rigorous studies, it has not been possible to draw firm conclusions on the average rate of refusal of psychotropic medications in acute psychiatry. However, it is clear that medication refusal is common and leads to poor outcomes characterized by higher rates of seclusion, restraint, threats of, and actual, assaults and longer hospitalizations. There are no statistically significant differences between refusers and acceptors in gender, marital status and preadmission living arrangements. Although no firm conclusions on the influence of ethnicity, status at admission and diagnosis on refusal, the refusers are more likely to have higher number of previous hospitalizations and history of prior refusal. The review indicates that staff factors such as the use of temporary staff, lack of confidence in ward staff and ineffective ward structure are associated with higher rates of medication refusal. Comprehensive knowledge of why, and how, patients refuse medication is lacking. Research on medication refusal is still fragmented, of variable methodological quality and lacks an integrating model.
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Document 4
Byrd, Serena; Shuman, Andrew G; Kileny, Sharon; Kileny, Paul R
The right not to hear: the ethics of parental refusal of hearing rehabilitation.
The Laryngoscope 2011 Aug; 121(8): 1800-4
Abstract: To explore the ethics of parental refusal of auditory-oral hearing rehabilitation.

Document 5
Barth, William H Jr.; Kwolek, Christopher J; Abrams, Joshua L; Ecker, Jeffrey L; Roberts, Drucilla J

Document 6
Hickey, Catherine
Case study. Devotion or disease? Commentary.
The Hastings Center report 2011 Mar-Apr; 41(2): 18-9

Document 7
Shuman, Andrew G; Barnosky, Andrew R
Exploring the limits of autonomy.
The Journal of emergency medicine 2011 Feb; 40(2): 229-32
Abstract: The ethical principle of autonomy is explored as it applies to situations in which patients' capacities to make decisions are questionable.

Document 8
Glod, William
Conditional preferences and refusal of treatment.
HEC forum : an interdisciplinary journal on hospitals' ethical and legal issues 2010 Dec; 22(4): 299-309
Abstract: In this essay, I will use a minimalist standard of decision-making capacity (DMC) to ascertain two cases in the medical ethics literature: the 1978 case of Mary C. Northerm and a more recent case involving a paranoid war veteran (call him Jack). In both cases the patients refuse medical treatment out of denial that they are genuinely ill. I believe these cases illustrate two matters: (1) the need of holding oneself to a minimal DMC standard so as to make as salient as possible the patient's own reasons for sometimes unusual treatment denials; (2) the need for clinicians and other relevant parties to exercise great sensitivity toward engaging, on the patient's own terms, idiosyncratic treatment refusals through regard for what I will call the patient's "conditional preferences." These are particularly relevant matters when a patient's DMC is questionable yet he/she registers what may well be his/her settled preferences.
**Document 9**

Zonana, Howard

*Physicians must honor refusal of treatment to restore competency by non-dangerous inmates on death row.*


**Abstract:** The role of physicians in death penalty cases has provoked discussion in both the legal system as well as in professional organizations. Professional groups have responded by developing ethical guidelines advising physicians as to current ethical standards. Psychiatric dilemmas as a subspecialty with unique roles have required more specific guidelines. A clinical vignette provides a focus to explicate the conflicts.

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**Document 10**

McDonnell, Melissa; Phillips, Robert T M

*Physicians should treat mentally ill death row inmates, even if treatment is refused.*


**Abstract:** Competency to be executed evaluations are conducted with a clear understanding that no physician-patient relationship exists. Treatment however, is not so neatly re-categorized in large measure because it involves the physician's active provision of the healing arts. A natural tension exists between what practices may be legally permissible and what are ethically acceptable. We present an overview of the existing positions on this matter in the process of framing our argument.

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**Document 11**

Epright, M Carmela

*Coercing future freedom: consent and capacities for autonomous choice.*


**Abstract:** In this paper I examine some of the significant moral concerns inherent in cases of treatment refusal involving patients with psychotic disorders. In particular, I explore the relevance of the principle of autonomy in such situations. After exploring the concept of autonomy and explaining its current and historical significance in a health care setting, I argue that because autonomous choice depends for its existence upon certain human functions such as the ability to reason, judge, and assess consequences, patients cannot be said to be making free and autonomous decisions if these capacities are compromised. I contend further that because psychotic disorders have the potential to compromise these functions in the future, it is appropriate, in some limited cases, to coerce patients with psychotic disorders to undergo treatment in order to preserve their future decision-making capacities and to protect their ability to recognize and respect the autonomy of others.

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**Document 12**

Erbay, Hasan; Alan, Sultan; Kadioglu, Selim

*A case study from the perspective of medical ethics: refusal of treatment in an ambulance*

Journal of Medical Ethics 2010 November 11; 36(11): 652-655

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[http://jme.bmj.com/content/36/11/652.full.pdf](http://jme.bmj.com/content/36/11/652.full.pdf) (link may be outdated)
Rational noncompliance with prescribed medical treatment.
Kennedy Institute of Ethics journal 2010 Sep; 20(3): 277-90

Abstract: Despite the attention that patient noncompliance has received from medical researchers, patient noncompliance remains poorly understood and difficult to alter. With a better theory of patient noncompliance, both greater success in achieving compliance and greater respect for patient decision making are likely. The theory presented, which uses a microeconomic approach, bridges a gap in the extant literature that has so far ignored the contributions of this classic perspective on decision making involving the tradeoff of costs and benefits. The model also generates a surprising conclusion: that patients are typically acting rationally when they refuse to comply with certain treatments. However, compliance is predicted to rise with increased benefits and reduced costs. The prediction that noncompliance is rational is especially true in chronic conditions at the point that treatment begins to move closer to the medically ideal treatment level. Although the details of this theory have not been tested empirically, it is well supported by existing prospective and retrospective studies.

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Why I wrote... Rights, Duties and the Body: Law and Ethics of the Maternal-Fetal Conflict
Clinical Ethics 2010 September; 5(3): 164-169

Reactions of pediatricians to refusals of medical treatment for minors.

Abstract: Treatment refusals in pediatrics must balance parental decision-making authority and best interest. General pediatricians and subspecialists were surveyed to understand the factors that influence their responses to refusals including (1) prognosis, (2) concordance of parent-minor decision, and (3) minor autonomy.

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Case study. Nursing ethics of treatment refusal by patients in Japan.
Nursing ethics 2010 Jul; 17(4): 523-6

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A piece of my mind. The "right" to fall.
JAMA : the journal of the American Medical Association 2010 Jun 16; 303(23): 2333-4

A great escape.
Annals of internal medicine 2010 Jun 15; 152(12): 821-2

The right to refuse: only for some?
The Florida nurse 2010 Jun; 58(2): 15

Der Anaesthesist 2010 Apr; 59(4): 289-92

Der Anaesthesist 2010 Apr; 59(4): 312-8

Abstract: The perioperative management of patients belonging to the faith of Jehovah's Witnesses poses two equally difficult problems for physicians due their strict refusal of allogeneic blood transfusions: From a medical point of view everything must be done to avoid fatal anemia and coagulopathy. On the other hand, the physician is confronted with the legal problem even in extreme cases, whether the wishes of the patient, i.e. the religiously
motivated right to self-determination, should or even must be followed when despite all preventative measures as
described in this case, the risk of fatality is only avoidable by a blood transfusion and therefore represents the only
life-saving option. In order to be able to answer this question this article supplies information on the unanimously
recognized conditions in the jurisdiction and prevailing legal opinion and derives the consequences for the physician
that this does not necessarily signify an unconditional legal obligation in association with a patient directive.

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**Document 24**

Habler, O; Voss, B

[Perioperative management of Jehovah's Witness patients. Special consideration of religiously motivated
refusal of allogeneic blood transfusion] = Perioperatives Management bei Zeugen Jehovas. Spezielle
Berücksichtigung der religiös motivierten Ablehnung von Fremdblut.

**Abstract:** The religious organization of Jehovah's Witnesses numbers more than 7 million members worldwide,
including 165,000 members in Germany. Although Jehovah's Witnesses strictly refuse the transfusion of allogeneic
red blood cells, platelets and plasma, Jehovah's Witness patients may nevertheless benefit from modern therapeutic
concepts including major surgical procedures without facing an excessive risk of death. The present review
describes the perioperative management of surgical Jehovah's Witness patients aiming to prevent fatal anemia and
coagulopathy. The cornerstones of this concept are 1) education of the patient about blood conservation techniques
generally accepted by Jehovah's Witnesses, 2) preoperative optimization of the cardiopulmonary status and
correction of preoperative anemia and coagulopathy, 3) perioperative collection of autologous blood, 4) minimization
of perioperative blood loss and 5) utilization of the organism's natural anemia tolerance and its acute accentuation in
the case of life-threatening anemia.

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**Document 25**

Fridén, Thomas; Silfverhielm, Helena

[When will the patient's no be a yes in care situations?] = När kan patientens nej bli ja i vårdsituationen?

Läkartidningen 2010 March 17-23; 107(11): 732-733

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**Document 26**

Jacobsen, Torsten B

[Coercion in psychiatry] = Tvang i psykiatrien.

Ugeskrift for læger 2010 Mar 15; 172(11): 900; author reply 900

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**Document 27**

Henningsen, Ebbe

[Coercion in psychiatry] = Tvang i psykiatrien.

Ugeskrift for læger 2010 Mar 15; 172(11): 901; author reply 901

Georgetown users check [Georgetown Journal Finder](#) for access to full text
What more in the name of god? Theologies and theodicies of faith healing.

Abstract: The recent deaths of two children from parental decisions to rely on faith healing rather than medical treatment raises fundamental questions about the extent and limits of religious liberty in a liberal democratic society. This essay seeks to identify and critically examine three central issues internal to the ethics of religious communities that engage in faith healing regarding children: (1) the various forms of religious and nonreligious justification for faith healing; (2) the moral, institutional, or metaphysical wrong of medical practice from the perspectives of faith-healing communities; (3) the explanation or "theodicy" articulated by the religious community when faith healing does not occur and a child dies. The essay finds that the holding in Prince v. Massachusetts that parents with religious convictions cannot enforce martyrdom on their children presents a guiding principle for medicine and public policy.

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Point counterpoint: mandatory flu vaccination for health care workers.
American Journal of Nursing 2010 January; 110(1): 26
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Olsen, Douglas P.
Point counterpoint: mandatory flu vaccination for health care workers.
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Converso, Ann R.
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Stewart, Alexandra M.
Mandatory vaccination of health care workers.
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Turley, Jonathan
When a child dies, faith is no defense; Why do courts give believers a pass?
Washington Post 2009 November 15; p. B1, B4

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Bashir, Fareed A.; Crawford, Mike
Autonomy or life saving treatment for the mentally vulnerable? [letter]
British Medical Journal 2009 October 31; 339(7728): 988
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Hartocollis, Anemona; Chan, Sewell
*Flu vaccine requirement for health workers is lifted*

**Document 39**
Steinhauer, Jennifer
*Swine flu shots revive a debate about vaccines*

**Document 40**
McLean, Sheila A.M.
*Live and let die.*
British Medical Journal 2009 October 10; 339(7725): 837

**Document 41**
Badger, James M.; Ladd, Rosalind Ekman; Adler, Paul
*Respecting patient autonomy versus protecting the patient's health*
JONA's Healthcare Law, Ethics, and Regulation 2009 October-December; 11(4): 120-126

**Document 42**
Badger, James M.; Ladd, Rosalind Ekman; Adler, Paul
*Respecting patient autonomy versus protecting the patient's health: a dilemma for healthcare providers.*
JONA'S Healthcare Law, Ethics and Regulation 2009 October-December; 11(4): 120-126

**Abstract:** A 74-year-old man with multiple chronic medical problems was hospitalized for respiratory distress. He experienced recurrent aspiration and required frequent suctioning and endotracheal intubation on several occasions. The patient was deemed competent and steadfastly refused feeding tube placement. The patient demanded that he be allowed to eat a normal diet despite being told that it could lead to his death. The patient wanted to go home, but there was no one there to care for him. Additionally, neither a nursing home nor hospice would accept him in his present condition. The case is especially interesting because of the symbolic value of food and the plight of the patient who has no alternative to hospitalization. The hospital staff experienced considerable stress at having to care for him. They were uncertain whether their obligation was to respect his autonomy and continue to provide food or to protect his health by avoiding aspiration, pneumonia, and possible death by denying him food. This ethical dilemma posed by the professionals' duty to do what is in the patient's best interest versus the patient's right to decide
treatment serves as the focus for this case study. Ethical, legal, and healthcare practitioners’ considerations are explored. The case study concludes with specific recommendations for treatment.

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Lyerly, Anne Drapkin; Little, Margaret Olivia; Faden, Ruth R.
Essay: Pregnancy is no time to refuse a flu shot

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* Document 44
Stein, Rob
Mandatory flu shots hit resistance; many health-care workers required to get vaccines
Washington Post 2009 September 26; p. A1, A

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* Document 45
McNeil, Donald G. Jr.; Zraick, Karen
New York health care workers resist flu vaccine rule

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* Document 46
Lemmens, Christophe
End-of-life decisions and minors: do minors have the right to refuse life preserving medical treatment? A comparative study

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* Document 47
Gill, Denis G.; Leask, Julie; McIntyre, Peter B.; Omer, Saad B.; Sanders, Daniel A.
Vaccine refusal and the risks of vaccine-preventable diseases [letters and reply]

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* Document 48
Brody, Benjamin

**Who has capacity? [commentary]**

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Ohto, Hitoshi; Yonemura, Yuji; Takeda, Junzo; Inada, Eiichi; Hanada, Ryoji; Hayakawa, Satoshi; Miyano, Takeshi; Kai, Katsunori; Iwashii, Waichiro; Muto, Kaori; Asai, Fumikazu;,

**Guidelines for managing conscientious objection to blood transfusion.**
Transfusion Medicine Reviews 2009 July; 23(3): 221-228

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Shimoda, Motomu

**Rationality of refusing treatment: Clinical Ethics Conference at the Department of Emergency Medicine**
Formosan Journal of Medical Humanities 2009 June; 10(1-2): 99-104

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Shimoda, Motomu

**Rationality of refusing treatment: Clinical Ethics Conference at the Department of Emergency Medicine**
Formosan Journal of Medical Humanities 2009 June; 10(1-2): 99-104

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Chigbu, Chibuike O.; Ezenyeaku, Cyril C.; Ezenkwele, Eziamaka

**Obstetricians' opinions and attitudes toward maternal refusal of recommended cesarean delivery in Nigeria.**

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DeRenzo, Evan G.

**Commentary on Berger's "Patients' concerns for family burden".**
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Derse, Arthur R.
*When I lay my burden down: commentary on Berger.*
Journal of Clinical Ethics 2009 Summer; 20(2): 172-174

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Minnesota: boy to get treatment
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Informed consent and informed refusal in Oklahoma.
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When religious beliefs collide with medicine.
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Cox, Jeannette

"Corrective" surgery and the Americans With Disabilities Act

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Hall, Mark A.; Schneider, Carl E.

When patients say no (to save money): an essay on the tectonics of health law

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Johnson, Dirk

Trials loom for parents who embraced faith over medicine

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Smith, Martha S.; Kalbeitzzer, Rachel; Packer, Ira K.

Diminished capacity and the right to refuse mental examination

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Blackwood, Karla; Guyer, Melvin

Involuntary medication to render a defendant competent to stand trial: Harper-like dangerousness assessment must precede a Sell hearing as a condition for forced medication to render a defendant competent to stand trial

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Singer, Natasha
In breast reconstruction, some hidden choices
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Dyer, Clare
Trust decides against action to force girl to undergo transplant [news]
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Britain debates a child's right to choose her own fate
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Case report: a pregnant Jehovah's witness
BMJ: British Medical Journal 2008 October 18; 337(7675): 939
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Eckholm, Erik
Innovative courts give some addicts chance to straighten out
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Gust, Deborah A.; Darling, Natalie; Kennedy, Allison; Schwartz, Ben
Parents with doubts about vaccines: which vaccines and reasons why
Pediatrics 2008 October; 122(4): 718-725
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Windish, Donna M.; Ratanawongsa, Neda
Providers' perceptions of relationships and professional roles when caring for patients who leave the hospital against medical advice.
Journal of General Internal Medicine 2008 October; 23(10): 1698-1707

Document 73
Winburn, E.; Mullen, R.
Personality disorder and competence to refuse treatment
Journal of Medical Ethics 2008 October; 34(10): 715-716
Abstract: The traditional view that having a personality disorder, unlike other mental disorders, is not usually reason enough to consider a person incompetent to make healthcare decisions is challenged. The example of a case in which a woman was treated for a physical disorder without her consent illustrates that personality disorder can render a person incompetent to refuse essential treatment, particularly because it can affect the doctor-patient relationship within which consent is given.

Document 74
Kallert, Thomas Wilhelm
Coercion in psychiatry.
Current Opinion in Psychiatry 2008 September; 21(5): 485-489

Document 75
Thiels, Cornelia
Forced treatment of patients with anorexia.
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Gullion, Jessica Smartt; Henry, Lisa; Gullion, Greg
Deciding to opt out of childhood vaccination mandates
Public Health Nursing 2008 September-October; 25(5): 401-408
**Document 77**

Duhon, Gary; Moazam, Farhat

An uncomfortable refusal [case study and commentary]


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Measles returns [editorial]

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Harris, Gardiner

Measles cases grow in number, and officials blame parents' fear of autism


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**Document 80**

Berlinger, Nancy

Beach blanket bioethics: a novel remedy for vaccination refusal


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**Document 81**

Grace, Pamela J.; Hardt, Eric J.

When a patient refuses assistance

American Journal of Nursing 2008 August; 108(8): 36-38

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**Document 82**

Prabhu, Aparna; Lockie, Jane

Children refusing general anaesthesia: to postpone or proceed?

British Journal of Hospital Medicine 2008 August; 69(8): 485

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Hui, Edwin
Parental refusal of life-saving treatments for adolescents: Chinese familism in medical decision-making revisited.
Bioethics 2008 June; 22(5): 286-295
Abstract: This paper reports two cases in Hong Kong involving two native Chinese adolescent cancer patients (APs) who were denied their rights to consent to necessary treatments refused by their parents, resulting in serious harm. We argue that the dynamics of the 'AP-physician-family-relationship' and the dominant role Chinese families play in medical decision-making (MDM) are best understood in terms of the tendency to hierarchy and parental authoritarianism in traditional Confucianism. This ethic has been confirmed and endorsed by various Chinese writers from Mainland China and Hong Kong. Rather than giving an unqualified endorsement to this ethic, based more on cultural sentimentalism than rational moral reasoning, we warn that a strong familism in MDM, which deprives 'weak' family members of rights, represents the less desirable elements of this tradition, against which healthcare professionals working in this cultural milieu need to safeguard. Specifically for APs, we suggest that parental authority and family integrity should be re-interpreted in terms of parental responsibility and the enhancement of children's interests respectively, as done in the West. This implies that when parents refuse to consent to necessary treatment and deny their adolescent children's right to consent, doctors, as the only remaining advocates of the APs' interest, have the duty to inform the state, which can override parental refusal to enable the doctors to fulfill their professional and moral obligations. In so doing the state exercises its 'parens patriae' power to defend the
defenseless in society and the integrity of the medical profession.

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**Document 88**

**Can you force treatment on a patient? New York lawsuit addresses key issues.**

ED Management 2008 May; 20(5): 49-51

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**Document 89**

Bruder, Jessica; Tims, Dana

**Parents plead not guilty in death; first charged in Oregon since faith-healing crackdown**

Washington Post 2008 April 5; p. B9

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Whyte, Alison

**A serious ethical dilemma.**

Nursing Standard 2008 April 2-8; 22(30): 18-19

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**Document 91**

Hua, May; Munson, Ronald; Lucas, Art; Rovelstad, Susan; Klingensmith, Mary; Kodner, Ira J.

**Medical treatment of Jehovah's witnesses.**

Surgery 2008 April; 143(4): 463-465

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**Document 92**

Webb, Lindsay J.

"Above these badlands": delusions, autonomy, and individual beliefs in right to refuse psychotropic medication cases


**Abstract:** This paper reviews the claim that matters of truth can be arbitrated through general consensus or agreement. Philosopher William James proposed two methods for establishing truth: First, we may be able to directly verify the truth of ideas by checking our hypotheses against the world. Second, when verification is not possible, truth can be approached through the utilization of consensus. There are some contexts in which a general consensus of truth will suffice. However, a mere consensus of truth is inadequate when reliance on such an agreement may result in the preservation or minimization of individual autonomy. Mental disability jurisprudence is often concerned with the preservation of individual autonomy. Yet, often, individual autonomy is cast aside in lieu of professional agreements. This is especially the case in right to refuse psychotropic medication cases.

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Document 93
Anesi, George; Baum, Carl; Colby, Laura; Duwe, Axel; Christie, Athalia; Gay, Andrea
When parents say no to vaccines [letters]
New York Times 2008 March 30; p. WK11

Document 94
Basharat, Pari
Denial, acceptance and the dreaded “D” word
CMAJ/JAMC: Canadian Medical Association Journal 2008 March 25; 178(7): 885-886

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Pacsi, Alsacia L.
Case study: an ethical dilemma involving a dying patient.
Journal of the New York State Nurses' Association 2008 Spring-Summer; 39(1): 4-7

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Mulnix, Jennifer Wilson
Case one: patient autonomy and the freedom to act against one's self-interest.
Clinical Laboratory Science 2008 Spring; 21(2): 114-115

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Duffin, Christian
No more bad blood.
Emergency Nurse 2008 March; 15(10): 18-21
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Campbell, Bruce H.
**Listening to Leviticus** [A piece of my mind]
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Rhodes, Rosamond
**Death or damnation: an adolescent's treatment refusal**
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Mackenzie, Catriona
**Relational autonomy, normative authority and perfectionism**
Georgetown users check [Georgetown Journal Finder](http://jama.ama-assn.org) for access to full text

Document 102
Mercurio, Mark R
**Adolescent's refusal of treatment: principles in conflict.**
Georgetown users check [Georgetown Journal Finder](http://www.bioethicsforum.org) for access to full text

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Sorrentino, Betty Robinson; Olsen, Douglas P.
**Unwanted treatment [letter and reply]**
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Veatch, Robert M.; Haddad, Amy
**Consent and the right to refuse treatment**
Call number: [RS100.5 .V43 2008](http://jama.ama-assn.org)
**Document 105**

Munson, Ronald, ed.

**Physicians, patients and others: autonomy, truth telling, and confidentiality**


Call number: R724 .I57 2008

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**Document 106**

Orentlicher, David; Bobinski, Mary Anne; Hall, Mark A.

**The right and "duty" to die**


Call number: KF3775 .O74 2008

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Rolon, Yamilka M.; Jones, Joshua C.W.

**Right to refuse treatment**


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**When is it permissible to dismiss a family who refuses vaccines? Legal, ethical and public health perspectives.**

Paediatrics & child health 2007 Dec; 12(10): 843-5

**Abstract:** Although immunization is one of the most important health interventions of the 20th century, cases of infectious disease continue to occur. There are parents who refuse immunization for their children, creating a dilemma for the primary care physician who must consider the best interest of the individual child as well as that of the community. Some physicians, when faced with parents who refuse immunization on behalf of their children, choose to dismiss these families from their practice. Given the existing shortage of primary care physicians across Canada, this decision to dismiss families based on vaccine refusal has far-reaching implications. The present article explores this issue in the Canadian context from a legal, ethical and public health perspective.

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Lewis, Ian; Burke, Constance; Voepel-Lewis, Terri; Tait, Alan R.

**Children who refuse anesthesia or sedation: a survey of anesthesiologists.**

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**An adolescent's refusal of medical treatment: implications of the Abraham Cheerix case.**

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Death by denomination: a Jehovah's right to die
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English, Dan C.

Addressing a patient's refusal of care based on religious beliefs.
American Family Physician 2007 November 1; 76(9): 1393-1394

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* Article Document 113

Russell, Barbara

The crucible of anorexia nervosa

Abstract: Anorexia nervosa (AN) is a very serious condition because of the suffering and loss of life that it causes. However, the wishes of the people directly involved can be strongly opposed. The person with severe AN may not want treatment, yet her family beseeches professionals to unilaterally intervene and clinical teams are divided over the defensibility of involuntary hospitalization and treatment. The metaphor of a crucible is used in this paper to help identify how much is at stake and how much is in conflict when someone has AN. Frank (2004) cautions against ethical analyses that rely mostly on substantive principles or rules and institutional conflict resolution procedures. This paper applies his heuristic concepts of "ethics-as-substance" and "ethics-as-process" to a prototypical AN case to illustrate how process activities can expand understanding of, and responsiveness to, those who are living with this dire condition or those who are obligated to help.

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Orr; Robert D.; Craig, Debra

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Permissibility to accept refusal of potentially life-saving treatment
Ethics and Medicine: An International Journal of Bioethics 2007 Summer; 23(2): 77-80

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Medical emergencies in children of orthodox Jehovah's Witness families: Three recent legal cases, ethical issues and proposals for management.
Paediatrics & child health 2007 May; 12(5): 385

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Medical emergencies in children of orthodox Jehovah's Witness families: Three recent legal cases, ethical issues and proposals for management.
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Medical emergencies in children of orthodox Jehovah's Witness families: Three recent legal cases, ethical issues and proposals for management.
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ENT surgery, blood and Jehovah's Witnesses.
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Martin Luther at the bedside: conscientious objection and community
Hastings Center Report 2007 March-April; 37(2): inside back cover

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Practical aspects of the issue of patients refusing medical care
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Mertl, Steve
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**Teen leaves "his only hope" behind in U.S. After 20 months, 14-year-old with leukemia returns home, saying no more chemotherapy or bone marrow transplants**

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Diaz, Karen L.
Refusal of medical treatment based on religious beliefs: Jehovah's Witness parents
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Right to refuse treatment: prisoner's claim that conditioning eligibility for parole on taking potentially medically inappropriate medication violated his due process rights is not frivolous
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Paris, John J.; Schreiber, Michael D.; Moreland, Michael P.
Parental refusal of medical treatment for a newborn
Theoretical Medicine and Bioethics 2007; 28(5): 427-441
Abstract: When there is a conflict between parents and the physician over appropriate care due to an infant whose decision prevails? What standard, if any, should guide such decisions?This article traces the varying standards articulated over the past three decades from the proposal in Duff and Campbell's 1973 essay that these decisions are best left to the parents to the Baby Doe Regs of the 1980s which required every life that could be salvaged be continued. We conclude with support for the policy articulated in the 2007 guidelines of the American Academy of Pediatrics on non-intervention or withdrawal of intensive care for high-risk newborns.
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Pence, Gregory E.
Treating Jehovah's Witnesses professionally
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Refusal of care by patients [letters and reply]
JAMA: The Journal of the American Medical Association 2006 December 27; 296(24): 2921-2923
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The man on the table was 97, but he devised the surgery

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White, Josh
Defense employees set for another suit to halt mandatory anthrax shots
Washington Post 2006 December 13; p. A19

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Hord, effrey D.; Rehman, Waqas; Hannon, Patricia; Anderson-Shaw, Lisa; Schmidt, Mary Lou
Do parents have the right to refuse standard treatment for their child with favorable-prognosis cancer? Ethical and legal concerns
Journal of Clinical Oncology 2006 December 1; 24(34): 5454-5456
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Guichon, Juliet; Mitchell, Ian
Medical emergencies in children of orthodox Jehovah's Witness families: Three recent legal cases, ethical issues and proposals for management.
Paediatrics & child health 2006 Dec; 11(10): 655-8
Abstract: Three recent Canadian legal cases have dealt with the proposed blood transfusion of adolescent members of Jehovah's Witness (JW) families. In each case, the court permitted transfusions if medically necessary. Much critical analysis of the issue of forced treatment of decisionally competent adolescents focuses exclusively on competence and questions why mature minors may not decide for themselves. The authors argue that a focus on decision-making competence alone is too narrow. Before one may legally give or refuse consent to medical treatment, three conditions must be met: competence, adequate information and lack of coercion. In striving to find agreement on medical treatment, physicians, patients and JW family members seek and, in fact, often achieve mutual understanding and cooperation. Coercion by actual or threatened shunning and excommunication can occur, and these factors may affect adolescent decision-making. In this context, a court order authorizing medical treatment can, therefore, be seen as enhancing patient freedom. The authors suggest that, in addition to fulfilling
existing statutory duties to report a child in need of protection, health care professionals caring for acute patients of JW families should actively look for evidence that the patient has accurate medical information and is acting without coercion. The authors also explore suggestions on how to deal with the unusual complexities of such cases.

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Caplan, Arthur
**The ethics of forced drug treatment for addicts**

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Chua, R.; Tham, K.F.
**Will "no blood" kill Jehovah Witnesses?**
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**A pathway for moral reasoning in home healthcare**
Home Healthcare Nurse 2006 November-December; 24(10): 654-661; quiz 670-671

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* **Article**  Document 153
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**Percutaneous feeding tube placement and severe anorexia nervosa**
Gastroenterology Nursing 2006 November-December; 29(6): 484-486

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**Between a rock and a court case [news]**
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**Competent patients’ refusal of nursing care**
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Green, Stephen A.; Bloch, Sidney
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Dagg, Paul
**John has Hepatitis and Schizophrenia**
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Dimond, Bridgit
**What is the law if a patient refuses treatment based on the nurse's race?**
Georgetown users check Georgetown Journal Finder for access to full text
Abstract: Hemodervative and blood transfusions without proper medical indication bring uncertain benefits, increase health risks and adverse effects. It is necessary to also consider the patient's values and preferences and the denial to receive transfusions. A deficient medical evaluation and an unnecessary transfusion can generate untoward effects regarding patients' health and safety.

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Olsen, Douglas P.

Should RNs be forced to get the flu vaccine?

AJN: American Journal of Nursing 2006 October; 106(10): 76-80

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Vialettes, B.; Samuelian-Massat, C.; Valéro, R.; Béliard, S.

The refusal of treatment in anorexia nervosa, an ethical conflict with three characters: "the girl, the family and the medical profession". Discussion in a French legislative context

Diabetes and Metabolism 2006 September; 32(4): 306-311

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Nenner, F.

A patient's choice [letter]

Journal of Medical Ethics 2006 September; 32(9): 554-555

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Fight over a child's care ends in compromise; Va. judge's order could have forced teen to get chemotherapy


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Refusal of care: patients' well-being and physicians' ethical obligations

JAMA: the Journal of the American Medical Association 2006 August 9; 296(6): 691-695

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Jones, James W.; McCullough, Laurence B.; Richman, Bruce W.
**Painted into a corner: unexpected complications in treating a Jehovah's Witness**

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Washington Post 2006 July 16; p. A6

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Washington Post 2006 July 16; p. A6

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Stein, Rob
**A medical crisis of conscience: faith drives some to refuse patients medication or care**

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Nocera, Joe
**If it’s good for Philip Morris, can it also be good for public health? The most surprising plan to reduce smoking may just be one backed by a tobacco executive**
New York Times Magazine 2006 June 18; p. 46-53, 70, 76-78
Open-heart surgery and Jehovah's Witnesses

Herczeg, L.; Szokol, J.; Horvath, G.; Vaszily, M.; Peterffy, A.

Abstract: The religious community of Jehovah's Witnesses holds that blood transfusion is against God's law. Therefore, surgical treatment of Jehovah's Witnesses is a great challenge for every surgeon, especially for cardiac surgeons because blood transfusion is frequently needed during such operations. In this study we summarize the experience with Jehovah's Witnesses who have undergone open-heart surgery in Debrecen from 1989 to 1999 due to various cardiac diseases. Applying a complex surgical procedure developed by the authors to minimize blood loss during operation, preserved blood products were omitted. Three patients out of twenty-four died during the postoperative period. The twenty-one longtime survivors showed significant improvement in their clinical stage during the mean follow up of 37.6 months. More and more operations are done successfully without blood or preserved blood products worldwide, so it could be said that nowadays surgical treatment of Jehovah's Witnesses has a lower risk than before.

Saying no is a patient's choice, however risky [essay]

Lemer, Barron H.

Abstract: Saying no is a patient's choice, however risky

New developing in mandatory blood testing legislation [news]

Garmaise, David

Abstract: The principle of informed refusal poses a specific problem when it is invoked by a pregnant woman who, in spite of having accepted her pregnancy, refuses the diagnostic and/or therapeutic measures that would ensure the well-being of her endangered fetus. Guidelines issued by professional bodies in the developed world are conflicting: either they allow autonomy and informed consent to be overruled to the benefit of the fetus, or they recommend the full respect of these principles. A number of medical ethicists advocate the overruling of alleged irrational or unreasonable refusal for the benefit of the fetus. The present essay supports the view of fetal rights to health and to life based on the principle that an 'accepted' fetus is a 'third person'. In developing countries, however, the
implementation of the latter principle is likely to be in conflict with a 'communitarian' perception of the individual - in this case, the pregnant woman. Within the scope of the limitations to the right to autonomy of J.S. Mill's 'harm principle', the South African Patients' Charter makes provision for informed refusal. The fact that, in practice, it is not implemented illustrates the well-known difficulty of applying Western bioethical principles in real life in the developing world.

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Killings loom over debate on treating mentally ill; New Mexico considers commitment law

New York Times 2006 February 8; p. A16

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Fritz, Mark

Strong medicine: a doctor's fight: more forced care for the mentally ill; Torrey's push for state laws sparks growing debate over rights of patients; Mr. Hadd goes underground

Wall Street Journal 2006 February 1; p. A1, A12

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Fischer, Jennifer

Comparative look at the right to refuse treatment for involuntarily hospitalized persons with a mental illness


Determinants of physician unwillingness to offer medical abortion using mifepristone

Women's Health Issues 2006 January-February; 16(1): 14-21

Abstract: PURPOSE: We sought to identify factors associated with contemplating versus not contemplating offering medical abortion with mifepristone among physicians not opposed to it. METHODS: We analyzed data from a Kaiser Family Foundation survey of a nationally representative sample of 790 American obstetrician/gynecologists and primary care physicians. Our study sample consisted of 419 physicians who were not personally opposed to medical abortion and could be classified as not actively considering (precontemplation) or actively considering (contemplation) offering mifepristone. We conducted multivariate logistic regression to predict being unlikely to offer...
mifepristone (i.e., in the precontemplation stage of change). PRINCIPAL FINDINGS: In 2001, 1 year after U.S. Food and Drug Administration (FDA) approval, 5% of physicians surveyed were offering mifepristone. Among the 750 physicians not offering mifepristone, 57% were not opposed. Of those not opposed, 74% reported that they were unlikely to offer mifepristone in the next year (precontemplation) as compared to 23% who might offer it (contemplation). Independent predictors of being in the precontemplation stage were being a primary care versus OB/GYN physician (odds ratio [OR] 3.29, p = .02), being in private versus hospital-based practice (OR 2.40, p = .03), and lacking concerns about FDA regulations (OR 2.06, p = .01) or violence and protests (OR 1.93, p = .03) as barriers to offering mifepristone. CONCLUSIONS: For precontemplation-stage physicians, the most efficient strategy for increasing the availability of medical abortion may be to design programs that emphasize clinical benefits and feasibility to stimulate interest in the procedure. For contemplation-stage physicians, the optimum approach may be one that helps to overcome barriers associated with FDA regulations and concerns about violence and protests.

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**Jehovah's Witnesses in the emergency department: what are their rights?**  
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**The practice of applying compulsory treatment to mentally disturbed people: a view from Russia**  
*Abstract:* The author describes the development of current legislation in Russia relative to compulsory medical treatment for mentally ill persons. He discusses these laws in relation to criminality and its prevention.  
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**A physician's challenge: cancer surgery, but "no blood"**  
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Adequacy of online medical command communication and emergency medical services documentation of informed refusals
Academic Emergency Medicine 2005 October; 12(10): 970-977
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JONA's Healthcare Law, Ethics, and Regulation 2005 October-December; 7(4): 105-111
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Saskatchewan: mandatory "bodily substances" testing legislation passed [news]
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*Hodgkin's returns to girl whose parents fought state: standoff ends as court hears test results*

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Journal of Contemporary Health Law and Policy 2005 Summer; 21(2): 235-258
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*Emancipation, capacity, and the difference between law and ethics [case study and commentary]*
Journal of Clinical Ethics 2005 Summer; 16(2): 144-150
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Journal of Clinical Ethics 2005 Summer; 16(2): 99-107

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**Ethics and medicine: clinical ethics dilemmas [case study and commentary]**
Ethics and Medicine 2005 Summer; 21(2): 89-93

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Murphy, Peter

**Are patients' decisions to refuse treatment binding on health care professionals?**
Bioethics 2005 June; 19(3): 189-201

**Abstract:** When patients refuse to receive medical treatment, the consequences of honouring their decisions can be tragic. This is no less true of patients who autonomously decide to refuse treatment. I distinguish three possible implications of these autonomous decisions. According to the Permissibility Claim, such a decision implies that it is permissible for the patient who has made the autonomous decision to forego medical treatment. According to the Anti-Paternalism Claim, it follows that health-care professionals are not morally permitted to treat that patient. According to the Binding Claim it follows that these decisions are binding on health-care professionals. My focus is the last claim. After arguing that it is importantly different from each of the first two claims, I give two arguments to show that it is false. One argument against the Binding Claim draws a comparison with cases in which patients autonomously choose perilous positive treatments. The other argument appeals to considered judgments about cases in which disincentives are used to deter patients from refusing sound treatments.

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Diekema, Douglas S.
American Academy of Pediatrics. Committee on Bioethics
Responding to parental refusals of immunization of children
Pediatrics 2005 May; 115(5): 1428-1431
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Jehovah's Witness children: when religion and the law collide
Paediatric Nursing 2005 April; 17(3): 34-37
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Limits on patient responsibility
Journal of Medicine and Philosophy 2005 April; 30(2): 189-206
Abstract: The medical profession and medical ethics currently place a greater emphasis on physician responsibility than patient responsibility. This imbalance is not due to accident or a mistake but, rather is motivated by strong moral reasons. As we debate the nature and extent of patient responsibility it is important to keep in mind the reasons for giving a relatively minimal role to patient responsibility in medical ethics. It is argued that the medical profession ought to be characterized by two moral asymmetries: (1) Even if some degree of responsible behavior from patients is called for, placing the dominant emphasis on professional responsibility over patient responsibility is largely correct. The value of protecting the right to refuse treatment and arguments against paternalism block a more expansive account of patient responsibility and support a strong notion of professional responsibility. (2) Insofar as we do want to encourage an increase in patient responsibility, we have good reasons to emphasize prospective rather than retrospective notions of responsibility in clinical practice. Concerns about patient vulnerability along with
the determined factors in disease leave little room for blame at the bedside. These two asymmetries generate normative limits on any positive account of patient responsibility.

* Document 214

Resnik, David B.

**The patient's duty to adhere to prescribed treatment: an ethical analysis**  
Journal of Medicine and Philosophy 2005 April; 30(2): 167-188

**Abstract:** This article examines the ethical basis for the patient's duty to adhere to the physician's treatment prescriptions. The article argues that patients have a moral duty to adhere to the physician's treatment prescriptions, once they have accepted treatment. Since patients still retain the right to refuse medical treatment, their duty to adhere to treatment prescriptions is a prima facie duty, which can be overridden by their other ethical duties. However, patients do not have the right to refuse to adhere to treatment prescriptions if their non-adherence poses a significant threat to other people. This paper also discusses the use of written agreements between physicians and patients as a strategy for promoting patient adherence.

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Blank, Arnold

**Respecting the autonomy of irrational patients [letter]**  
Archives of Internal Medicine 2005 March 14; 165(5): 590

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McInroy, Ally

**Blood transfusion and Jehovah's Witnesses: the legal and ethical issues**  
British Journal of Nursing 2005 March 10-23; 14(5): 270-274

* Document 217


**Coercion in the treatment of anorexia nervosa: clinical, ethical and legal implications**  

**Abstract:** Because of its high mortality and treatment resistance, clinicians sometimes invoke the law in aid of retaining their most acutely ill-patients in treatment or re-feeding programs. Depending on the jurisdiction, various laws, including mental health and adult guardianship laws, have been invoked to achieve this objective (Carney, Tait, Saunders, Touyz & Beumont, 2003). Until recently, little was known about the therapeutic impact of coercion on patients (Saunders, 2001, Carney & Saunders 2003), or the relative advantages of different avenues of coercion (Carney, Saunders, Tait, Touyz & Ingvarson 2004). Most obscure of all, however, has been our understanding of the factors influencing clinical decisions within specialist anorexia treatment units regarding which in-patients will be selected for coerced treatment. This paper reports legal and ethical implications of findings from analysis of data gathered from a major Australian specialist anorexia treatment facility over nearly 5 years.
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Fleming, Sheena

The pregnant woman's right to say no: a personal reflection [opinion]
RCM Midwives 2005 March; 8(3): 106-107

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van Kleffens, T.; van Leeuwen, E.

Physicians' evaluations of patients' decisions to refuse oncological treatment
Journal of Medical Ethics 2005 March; 31(3): 131-136

Abstract: OBJECTIVE: To gain insight into the standards of rationality that physicians use when evaluating patients' treatment refusals. DESIGN OF THE STUDY: Qualitative design with in depth interviews. PARTICIPANTS: The study sample included 30 patients with cancer and 16 physicians (oncologists and general practitioners). All patients had refused a recommended oncological treatment. RESULTS: Patients base their treatment refusals mainly on personal values and/or experience. Physicians mainly emphasise the medical perspective when evaluating patients' treatment refusals. From a medical perspective, a patient's treatment refusal based on personal values and experience is generally evaluated as irrational and difficult to accept, especially when it concerns a curative treatment. Physicians have a different attitude towards non-curative treatments and have less difficulty accepting a patient's refusal of these treatments. Thus, an important factor in the physician's evaluation of a treatment refusal is whether the treatment refused is curative or non-curative. CONCLUSION: Physicians mainly use goal oriented and patients mainly value oriented rationality, but in the case of non-curative treatment refusal, physicians give more emphasis to value oriented rationality. A consensus between the value oriented approaches of patient and physician may then emerge, leading to the patient's decision being understood and accepted by the physician. The physician's acceptance is crucial to his or her attitude towards the patient. It contributes to the patient's feeling free to decide, and being understood and respected, and thus to a better physician-patient relationship.

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Martins, David S.

Compliance rhetoric and the impoverishment of context
Communication Theory 2005 February; 15(1): 59-77

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McQuoid-Mason, David

Parental refusal of blood transfusions for minor children solely on religious grounds -- the doctor's dilemma resolved

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Linnard-Palmer, Luanne; Kools, Susan

Parents' refusal of medical treatment for cultural or religious beliefs: an ethnographic study of health care
**Document 223**

Lyng, Kristin; Syse, Aslak; Bordahl, Per E.

**Can cesarean section be performed without the woman's consent?**


Georgetown users check Georgetown Journal Finder for access to full text

**Abstract:**
Competent patients who refuse life saving medical treatment present a dilemma for healthcare professionals. On one hand, respect for autonomy and liberty demand that physicians respect a patient's decision to refuse treatment. However, it is often apparent that such patients are not fully competent. They may not adequately comprehend the benefits of medical care, be overly anxious about pain, or discount the value of their future state of health. Although most bioethicists are convinced that partial autonomy or marginal competence of this kind demands the same respect as full autonomy, Israeli legislators created a mechanism to allow ethics committees to override patients' informed refusal and treat them against their will. To do so, three conditions must be satisfied: physicians must make every effort to ensure the patient understands the risks of non-treatment, the treatment physicians propose must offer a realistic chance of significant improvement, and there are reasonable expectations that the patient will consent retroactively. Although not all of these conditions are equally cogent, they offer a way forward to assure care for certain classes of competent patients without abandoning the principle of autonomy altogether. These concerns reach past Israel and should engage healthcare professionals wary that respect for autonomy may sometimes cause avoidable harm.

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Yosef Kurtam v. State of Israel


Call number: BM538 .H43 J48 2005

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Brecht, Mary-Lynn; Anglin, M. Douglas; Dylan, Michelle

**Coerced treatment for methamphetamine abuse: differential patient characteristics and outcomes**


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Lawton-Smith, Simon

**A question of numbers: the potential impact of community based treatment orders in England and Wales**


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Ackermann, Deonna; Chapman, Simon; Leask, Julie

**Media coverage of anthrax vaccination refusal by Australian Defence Force personnel**

Vaccine 2004 December 2; 23(3): 411-417

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**Nova Scotia: "blood samples" legislation passed**


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Sewell, Adrian C.; Gebhardt, Boris; Herwig, Jurgen; Rauterberg, Ernst W.

**Acceptance of extended newborn screening: the problem of parental non-compliance**


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Pollitt, Rodney J.

**Compliance with science: consent or coercion in newborn screening**

European Journal of Pediatrics 2004 December; 163(12): 757-758

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Maclaren, G.; Anderson, M.
Bloodless intensive care: a case series and review of Jehovah’s Witnesses in ICU
Anaesthesia and Intensive Care 2004 December; 32(6): 798-803

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* Article Document 234
American College of Obstetricians and Gynecologists [ACOG]. Committee on Professional Liability
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Obstetrics and Gynecology 2004 December; 104(6): 1465-1466

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Smith, George P., II
"Just say no!": the right to refuse psychotropic medication in long-term care facilities

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Annas, George J.
Extremely preterm birth and parental authority to refuse treatment -- the case of Sidney Miller
New England Journal of Medicine 2004 November 11; 351(20): 2118-2123

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Kennedy, Wendy
Beneficence and autonomy in nursing: a moral dilemma
British Journal of Perioperative Nursing 2004 November; 14(11): 500-506

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* Article Document 238
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Ms. B and legal competence: interprofessional collaboration and nurse autonomy
Nursing in Critical Care 2004 November-December; 9(6): 271-276

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Oliver, Samuel L.; Baumrucker, Steven J. Rousseau, Paul; Stolick, Matt; Morris, Gerald M.; Ufema, Joy
Case study: death or damnation -- refusing life-prolonging therapy on religious grounds
American Journal of Hospice and Palliative Medicine 2004 November-December; 21(6): 469-473
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Zupan, Daniel; Solis, Gary; Schoonhoven, Richard; Annas, George

**Dialysis for a prisoner of war [case study and commentaries]**

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**Parents refusing medications for children in clinical trials [news]**

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Linnard-Palmer, Luanne; Kools, Susan

**Parents' refusal of medical treatment based on religious and/or cultural beliefs: the law, ethical principles, and clinical implications**


Document 243

Hurst, Samia A.

**When patients refuse assessment of decision-making capacity – how should clinicians respond?**

Archives of Internal Medicine 2004 September 13; 164(16): 1757-1760

*Abstract:* When patients refuse beneficial treatment, the assessment of decision-making capacity plays a key role in determining the best course of action. However, situations in which patients refuse to explain their reasons occur. This can make an assessment of capacity impossible. In such cases, clinicians find themselves in difficult situations without clear ethical guidance. Refusal to give reasons for refusing beneficial treatment has been seen as pointing to the absence of decision-making capacity. However, the reasons given for this are either unsatisfactory or insufficient to eliminate cases of genuine uncertainty. This article argues that although it cannot be concluded that such patients are incompetent, there are reasons to treat them as if they were. The basis of this possibility, however, points to several obligations for clinicians before such a situation can be said to exist.

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**Management of Jehovah's Witness patients with haematological problems**

Blood Reviews 2004 September; 18(3): 211-217
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Enigmatic refusals: the difference between a potential problem and one in a patient under our care
Chest 2004 August; 126(2): 337-339

Bramstedt, Katrina A.; Arroliga, Alejandro C.
On the dilemma of enigmatic refusal of life-saving therapy
Chest 2004 August; 126(2): 630-633

Aveyard, H.
The patient who refuses nursing care
Journal of Medical Ethics 2004 August; 30(4): 346-350

Abstract: OBJECTIVES: The aim of this paper is to examine the way in which nurses manage patients who refuse nursing care procedures. DESIGN: This paper reports on a qualitative study which was undertaken to explore the way in which nurses obtain consent prior to nursing care procedures. Focus groups were carried out to obtain background data concerning how consent is obtained. Critical incidents were collected through in depth interviews as a means of focusing on specific incidents in clinical practice. SETTING: Two teaching hospitals in England. PARTICIPANTS: Purposive sample of qualified nurses. RESULTS: When a patient refuses nursing care, nurses respond by giving information until the patient finally accedes to the procedure. Nurses will go to great lengths to achieve patients' agreement to the procedure, but the extent to which the agreement remains voluntary cannot be ascertained by the data collected in this study. If the patient does not eventually agree to a procedure, there is evidence that nurses will administer the care in the absence of consent. CONCLUSIONS: Nurses are concerned to obtain the patient's consent prior to the administration of nursing care but if this cannot be achieved do not regard obtaining consent as an absolute requirement. Consent is preferred, but not considered essential. Nurses have some understanding of the principles of informed consent but do not apply them to everyday clinical nursing practice.

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**The Constitution at the threshold of life and death: a suggested approach to accommodate an interest in life and a right to die**

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**Childhood immunization refusal: provider and parent perceptions**
Family Medicine 2004 June; 36(6): 431-439

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New York Times 2004 April 12; p. A19

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Annals of Pharmacotherapy 2004 April; 38(4): 621-624

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Who can stay at home? Assessing the capacity to choose to live in the community
Archives of Internal Medicine 2004 February 23; 164(4): 357-360

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Do Fourteenth Amendment considerations outweigh a potential state interest in mandating cochlear
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Rouge-Maillart, C.; Jousset, J.; Gaches, T.; Gaudin, A.; Penneau, M.
Patients refusing medical attention: the case of Jehovah's Witnesses in France

Abstract: Respect for the wishes of a patient is internationally accepted as standard medical practice. In French law, this principle is enshrined in the Civil Code of 1994 which concerns bioethics. More recently in 2002, we find it included in the Code of Public Health (in the law concerning patient's rights). According to these texts, the patient's wishes must always be respected even when his life is at stake, so long as the patient has been informed of the risk. The refusal by Jehovah's witnesses to receive blood transfusion always poses a problem. When, in full consciousness, a patient refuses a blood transfusion his life depends on, what should the doctor do? In June 1998, the Paris Administrative Court of Appeals ruled on such a case. The judges found that. In October 2001, the State Council decided in this particular case, that given the critical situation and the absence of a therapeutic alternative, the doctor had not committed an error. But it also clearly reiterated that the doctor is required to respect the wishes of the patient and that this obligation does not override the duty of saving a life. Two emergency interim rulings by the Lille Administration Court (25th August, 2002,) and by the State Council (6th August, 2002) confirm the position
of the judges. Not respecting the patient's wishes is a great infringement of individual freedom. The doctor will not err only under extreme and precise conditions. Should the doctor go against those wishes? Should the wishes of the patient be respected when their life is at stake? The authors will discuss these two questions.

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Diekema, Douglas S.
Parental refusals of medical treatment: the harm principle as threshold for state intervention
Abstract: Minors are generally considered incompetent to provide legally binding decisions regarding their health care, and parents or guardians are empowered to make those decisions on their behalf. Parental authority is not absolute, however, and when a parent acts contrary to the best interests of a child, the state may intervene. The best interests standard is the threshold most frequently employed in challenging a parent's refusal to provide consent for a child's medical care. In this paper, I will argue that the best interest standard provides insufficient guidance for decision-making regarding children and does not reflect the actual standard used by medical providers and courts. Rather, I will suggest that the Harm Principle provides a more appropriate threshold for state intervention than the Best Interest standard. Finally, I will suggest a series of criteria that can be used in deciding whether the state should intervene in a parent's decision to refuse medical care on behalf of a child.

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**Abstract:** The judgment handed down in the case of Ms B confirms the right of the competent patient to refuse medical treatment even if the result is death. The case does, however, raise some interesting legal points. The facility for conscientious objection by doctors has not previously been explicitly recognised in case law. More importantly perhaps is that the detailed inquiry by the court into Ms B's reasons for refusing treatment, apparently as a precondition for finding her competent, seems to contradict earlier case law where it has been asserted that competent patients can refuse treatment for no reason at all.

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**Abstract:** Individuals with major depression may benefit from psychiatric treatment, yet they may refuse such treatment, sometimes because of their depression. Hence the question is raised whether such individuals are competent to refuse psychiatric treatment. The standard notion of competence to consent to treatment, which refers to expression of choice, understanding of medical information, appreciation of the personal relevance of this information, and logical reasoning, may be insufficient to address this question. This is so because major depression may not impair these four abilities while it may disrupt coherence of personal preferences by changing them. Such change may be evaluated by comparing the treatment preferences of the individual during the depression to his or her treatment preferences during normal periods. If these preferences are consistent, they should be respected. If they are not consistent, or past treatment preferences that were arrived at competently cannot be established, treatment refusal may have to be overridden or ignored so as to alleviate the depression and then determine the competent treatment decision of the individual. Further study of the relation between depression and competence to refuse or consent to psychiatric treatment is required.

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