

C A S E R E P O R T

Patient's refusal of emergency care and the right to self-determination: A case report and related ethical and legal aspects

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ABSTRACT

Background: Consent and refusal of care are pivotal issues in clinical practice, underscored by the legal protection of self-determination. Obtaining informed consent is a rigorous process requiring clear communication to enable patients' autonomous decisions. When a patient with legal capacity refuses care, clinicians have a legal and ethical duty to assess decision-making capacity, verify understanding of the risks and benefits, communicate the consequences of refusal and propose appropriate alternative interventions, respecting the patient's will. In emergency situations, this process is further complicated by time pressures and other patient related factors.

Methods: We report a case involving a legally competent patient with bowel ischemia who refused emergency surgical intervention, described in accordance with the CARE guidelines. The case was identified during routine clinical practice and selected due to its ethical and legal relevance in the context of treatment refusal in emergency care. Clinical data were retrospectively collected from medical records, including clinical notes, diagnostic findings, and documentation related to informed consent and refusal. The patient's decision-making capacity was clinically assessed and documented by the treating physicians. The information provided to the patient regarding diagnosis, prognosis, risks, benefits, and available treatment alternatives was documented. The case



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was analyzed from a medico-legal perspective by comparing clinical management with current ethical principles on informed consent and refusal of treatment.

Conclusion: The fundamental right of patient self-determination, exercised through consent or refusal, must be respected in all clinical settings, and healthcare practitioners are obliged to provide adequate information to support informed decision-making. Meticulous documentation of the entire decision-making process is essential to safeguard both patient rights and clinicians' legal responsibilities. (www.actabiomedica.it)

Key words: refusal, self-determination, consent

Introduction

The principle of self-determination affirms an individual's right to decide whether to consent to proposed care (1). Scientific literature highlights various aspects of this principle. A patient must be competent and provided with sufficient information to make an informed decision (2). The law outlines exceptions in specific circumstances, such as mandatory treatment in certain psychiatric disorders. Practitioners are required to include patients in decision making process and guaranty continuity of care considering their wishes (3). This paper aims to analyze the issue of informed refusal of care in emergency situations, with a focus on the principle of patient self-determination and its clinical and medico-legal implications within the context of Italian legislation. Through the description of a paradigmatic clinical case, the paper seeks to prompt reflection on the critical issues that healthcare professionals may face when managing a competent patient's refusal of treatment, emphasizing the importance of assessing decision-making capacity and ensuring adequate communication and documentation of the decision-making process.

Case report

A 79-year-old female patient was brought to the emergency department (ED) with acute abdominal pain and an episode of vomiting, without fever or changes in bowel function. Her medical history was

significant for moderately reduced ejection-fraction heart failure due to dilated cardiomyopathy, permanent atrial fibrillation, arterial hypertension, type 2 diabetes mellitus, chronic renal failure, obesity, cholelithiasis, and hypothyroidism. She regularly took furosemide, bisoprolol, digoxin, edoxaban, canrenone, dapagliflozin, pravastatin, febuxostat, both rapid- and long-acting insulin, levothyroxine, and pantoprazole. On presentation to the ED, her vital signs were unstable: blood pressure 70/40 mmHg, heart rate 115 bpm, peripheral oxygen saturation 92%, and body temperature 38°C. Initial blood tests revealed: white blood cells count $17.5 \times 10^3/\mu\text{L}$ ($4.00\text{-}10.80 \times 10^3/\mu\text{L}$), neutrophils count $16.4 \times 10^3/\mu\text{L}$ ($1.50\text{-}8.50 \times 10^3/\mu\text{L}$), hemoglobin 10.4 g/dL (14.0-18.0 g/dL), platelets count $472 \times 10^3/\mu\text{L}$ ($130\text{-}400 \times 10^3/\mu\text{L}$), C-reactive protein 518 mg/L (<5,0 mg/L), creatinine 3.4 mg/dL (0.70-1.20 mg/dl), sodium 128 mmol/L (136-145 mmol/L), potassium 4.4 mmol/L (3.4-4.5 mmol/L), total bilirubin 0.81 mg/dL (<1.2 mg/dl), AST 8 U/L (18-39 U/L), ALT 10 U/L (10-50 U/L), lipase 28 U/L (13-60 U/L), INR 1.5, fibrinogen 857 mg/dL (170-420 mg/dL), and serum edoxaban 165 ng/L. The patient was alert, and her abdomen was tender. Despite adequate fluid resuscitation, blood pressure remained low, necessitating initiation of norepinephrine, along with empiric antibiotic therapy consisting of piperacillin/tazobactam and a single dose of amikacin. IV morphine was given for the treatment of pain. Echocardiography revealed a reduced ejection fraction. Abdominal Computed Tomography (CT) scan showed non-occlusive intestinal ischemia (Figure 1),

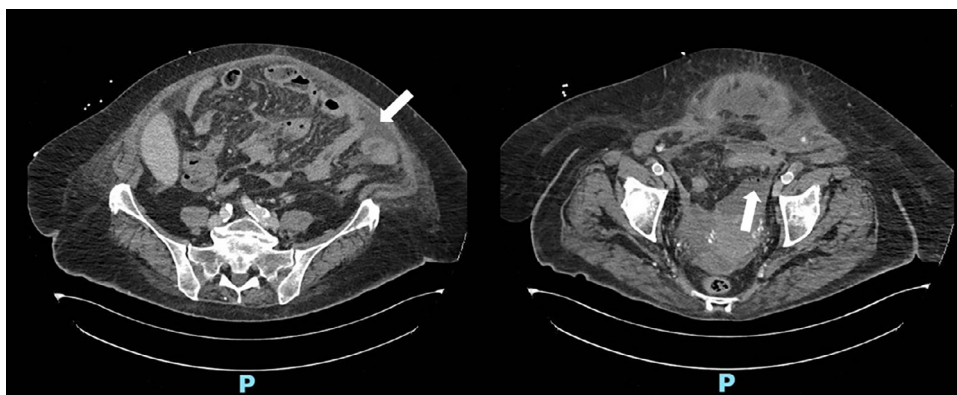


Figure 1. Abdomen CT scan on day 1 showing peritoneal fluid and air.

peritoneal fluid, and some air bubbles, highly suspicious for microperforation. In the presence of family members, an exploratory laparotomy was proposed by the on-call surgeon, despite a high intraoperative risk (American Society of Anesthesiologists–ASA class V), but the patient explicitly refused the procedure stating that she had enough health issues and could not accept further deterioration in her quality of life, should she survive the surgical intervention. She was admitted to the Emergency Medicine Unit, where antimicrobial therapy was escalated to include caspofungin. Vasopressor support was discontinued on day 3. Given the absence of symptoms upon de-escalation of pain treatment, normalization of bowel function, and unchanged CT findings, oral feeding was resumed on day 6. The patient’s children were summoned by the attending physician and were informed of the high likelihood of treatment failure; the potential consequences were then discussed in the patient’s presence. Concluding a 10-days antimicrobial therapeutic cycle, on day 21, she was transferred to a sub-acute care facility to await rehabilitation. On day 24, the patient developed hemodynamic instability and acute abdominal pain, requiring vasopressor support and re-initiation of antibiotic therapy. She was readmitted to the Emergency Medicine Unit. Repeat CT imaging revealed large intra-abdominal abscess (Figure 2). Once again, the patient declined the proposed surgical intervention. An infectious disease specialist recommended evaluation for percutaneous drainage, which was deemed unlikely to resolve the condition and was

ruled out by the surgical team. On day 27, while receiving prophylactic low-molecular-weight-heparin, the patient developed sudden expressive aphasia and left hemiparesis (National Institutes of Health Stroke Scale - NIHSS score 7). A head CT angiography revealed the occlusion of a branch of the left middle cerebral artery. Fibrinolysis was contraindicated due to the high risk of intra-abdominal hemorrhage. Given the repeated refusal of proposed surgical intervention by the patient, failure of antibiotic treatment, and the added complication of a new-onset stroke, the patient was transferred to a hospice facility on day 34, where the focus shifted to pain management through escalating doses of opioid therapy. Beginning on day 55, her condition deteriorated rapidly, necessitating intravenous administration of morphine and haloperidol. She passed away on day 58.

Discussion

The issue of refusal and renunciation of medical treatment remains a central topic in bioethical debate. It is firmly established that informed consent cannot be presumed implicitly nor automatically derived from the fact that a physician’s actions are intended to promote the patient’s well-being. In modern medical ethics, informed consent represents an essential requirement, as it ensures full recognition of the decisions made by a competent patient, in accordance with the principle of self-determination (4, 5). This principle is currently regulated

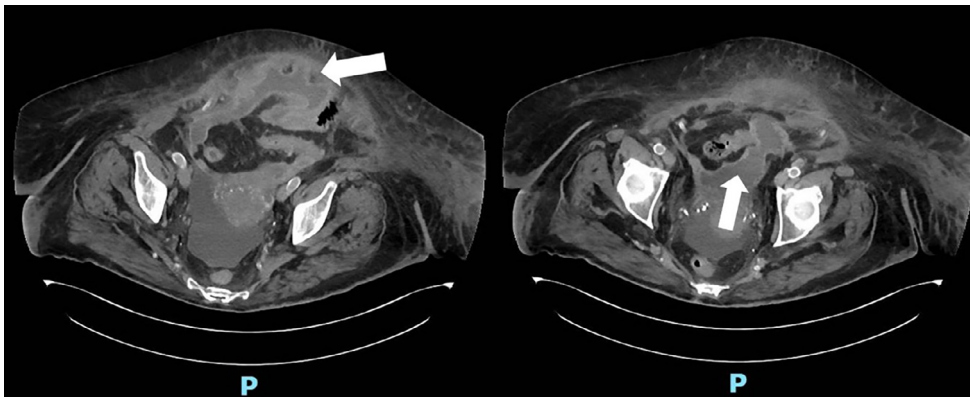


Figure 2. Abdomen CT scan on day 24 showing abscess.

in Italy by Law No. 219 of December 22, 2017, “Provisions on informed consent and advance directives for treatment.” The law emphasizes the relationship of care and trust between patient and physician, founded on informed consent, where the patient’s decisional autonomy intersects with the physician’s professional responsibility. It further affirms the right of a capable individual to refuse wholly or partially any form of recommended care. Moreover, an individual has the right to revoke an expressed consent at any time, even when such revocation results in treatment interruption. This regulatory framework aligns the Italian legal system with broader European and international standards recognizing patient autonomy as a fundamental human right. (1, 6). According to the Italian National Bioethics Committee, “refusal” refers to a person’s request not to initiate a therapy, while “renunciation” denotes the discontinuation of an ongoing therapy (4). It is important to distinguish between refusing treatment and making other end-of-life decisions, such as medically assisted suicide or euthanasia. Although they share an ethical basis of autonomy and human dignity, refusal of treatment is an exercise of negative freedom based on the right to bodily integrity. It does not involve the physician playing an active role in causing death. Euthanasia refers to the act, carried out by an individual, of intentionally ending a person’s life at their explicit and voluntary request to alleviate suffering from a terminal illness with poor prognosis. It can be classified as active, when death is directly induced (e.g., via lethal injection), or passive,

when life-sustaining treatment is withheld or withdrawn. Nevertheless, some situations are not classified as euthanasia: “deaths resulting from the refusal or withdrawal of life-sustaining treatment by a competent and conscious patient do not fall under euthanasia. Similarly, premature deaths that occur in accordance with the bioethical principle of double effect—wherein an adverse outcome, such as death, is tolerated if it arises as an unintended consequence of a treatment aimed at relieving suffering, such as appropriate palliative care—are also not classified as euthanasia” (7). Medically assisted suicide differs in that the patient self-administers lethal drugs. In Italy, it is currently regulated by Constitutional Court ruling no. 242/2019, while euthanasia remains illegal (8). In the face of treatment refusal or renunciation, it is imperative for the healthcare team to assess the patient’s decision-making capacity. It is necessary to exclude the presence of conditions that may impair such capacity, including cognitive impairments, neurological disorders, and alcohol and substance intoxication, often through the involvement of relevant specialists. Decision-making capacity may fluctuate over time, especially in the elderly or critically ill patients (9). Although chronological age alone is not associated with impaired capacity, cognitive disorders remain the primary cause of incapacity among the elderly (10). Competent patients understand why a treatment is proposed, the associated risks and benefits, the consequences of refusal and subsequently decide (2). In certain cases, consultation with specialists such as psychiatrists may be necessary to

identify additional factors that could influence the decision-making process (11). In cases where patients lack decision-making capacity, it is essential to verify the existence of advanced directives. In their absence, the procedure for appointing a Support Administrator must be initiated (12). While patients possess the legal right to refuse even life-sustaining medical treatments, patient refusal imposes legal obligations upon physicians. Physicians should provide complete, proportionate, and comprehensible information to the patients. When a competent patient declines recommended care, the physician is obliged to inform the patient of the consequences, except when the patient expressly declines such information, according to Law No. 219 of December 22, 2017. The conditions required for an action to be deemed autonomous include intentionality, adequate understanding of the circumstances, and absence of external influences (13). Refusal of medical treatment in emergency settings, where rapid decisions must be made regarding pathological conditions necessitating time-dependent care, presents significant clinical, ethical, and organizational challenges. Risk-benefit assessment of diagnostic and treatment procedures may not be readily comprehensible, particularly in patients lacking a healthcare background or experiencing acute stress (14). Renunciation or refusal of a proposed care by the patient does not automatically terminate the trust relationship between physician and patient; rather, it initiates a new phase of care in which the physician is called upon to provide alternatives in order to ensure the highest possible quality of care (4). The physician must not only elucidate all aspects related to the pathology, its treatment, and associated benefits and risks, but also explore the patient's values, concerns, and underlying reasons for refusal (10). The decision to refuse a certain form of care must be contextualized within the patient's biographical and motivational framework. From this standpoint, it may be helpful to involve family members, with the patient's consent, as requests to discontinue an ongoing treatment invite a more nuanced reflection on the complexity of patient-caregiver relationship, which often extends beyond a dyadic model (4). The experience of illness and subsequent medical treatment often entails considerable emotional burden. In certain cases, this may manifest as anxiety toward the healthcare system or a potential diagnosis, concerns that may be alleviated

through the involvement of family members. However, it should be emphasized that the decision to accept or refuse treatment rests exclusively on the competent patient. Available literature highlights a variety of reasons for treatment refusal, including cultural and religious factors, concerns about side effects, previous negative experiences, and perceptions of loss of control within the doctor-patient relationship (15, 16). The experience of illness and subsequent medical treatment often entails considerable emotional burden. In certain cases, this may manifest as anxiety toward the healthcare system or a potential diagnosis, concerns that may be alleviated through the involvement of family members. Practical constraints also play a substantial role: patients may bear responsibilities toward children, ill or disabled relatives, or pets, as well as financial pressures and job insecurity, may significantly influence decision-making. Moreover, in emergency departments, the high levels of anxiety and stress experienced by patients can impair their ability to process complex information, increasing the risk of poorly reasoned decisions. Communication and shared decision-making are important in addressing the patient's individual concerns (10). The refusal of care constitutes a circumstance that raises concern and warrants profound ethical and deontological reflection among healthcare professionals. Failure to assess decision-making capacity, provide adequate disclosure, or document the refusal process appropriately may expose physicians and healthcare facilities to civil or criminal liability. Conversely, accurate and traceable documentation of the entire decision-making process is essential for legal protection. According to Article 1, paragraph 6 of Law 219/2017, "The doctor is required to respect the patient's expressed wish to refuse or withdraw from medical treatment and, as a result, is exempt from civil or criminal liability...". Adopting a multidisciplinary approach in complex clinical situations, including consultations with psychiatrists, neurologists and other specialists or ethics committees, can enhance the robustness of the decision-making process. Clinical ethics consultation services are particularly valuable when life-saving treatments are refused (17, 18). As previously mentioned, refusal of treatment does not interrupt the duty of care but redefines its scope. Responsibility lies not only with individual clinicians, but also with healthcare organizations, which must ensure appropriate

alternative care pathways, including the early activation of palliative care when refusal involves life-sustaining treatment and prognosis is poor (19).

Conclusion

In cases where a patient refuses care, the right to self-determination must be examined considering clinical, ethical and legal foundations, and considered within the context of the patient's personal history and relational environment. Once the refusal is deemed well-founded, it is incumbent upon the healthcare professionals to identify the most appropriate alternative to ensure continuity of care. A structured, multidisciplinary approach and comprehensive documentation of the entire decision-making process is also essential to protect the patient's rights and reduce the medical-legal risk for professionals and healthcare facilities.

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