



Spring 2021 Edition

## Can Physicians and Clinical Ethicists Remain Neutral Toward Religious Beliefs?

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A familiar ethical dilemma arises when parents engage in religiously motivated refusals of medical care for their children. In cases where withholding treatment is likely to have serious health consequences for the child, it is generally accepted that it is permissible for a physician to override the parents' refusal.<sup>1</sup> It's also thought that a physician can provide ethical justifications for doing this while remaining neutral about the religious beliefs in question. Indeed, a number of authors argue that physicians and clinical ethicists *should* remain neutral with respect to the religious beliefs of their patients.<sup>2,3</sup>

Against this, ethicist Abram Brummett has recently argued that health care professionals who maintain that it's ethically permissible (or even obligatory) to override these religiously motivated refusals cannot consistently remain neutral on the religious beliefs in question.<sup>4</sup> To understand how Brummett's argument works, take the example of the belief among Jehovah's Witnesses that receiving a blood transfusion jeopardizes one's eternal salvation. Call this belief (JW). Consider a case in which parents refuse a blood transfusion for their child on this basis.

One might be inclined to think that one can sidestep the question of truth or falsity of (JW), and that an ethical justification for overriding the parental refusal can be offered on the basis of purely secular reasons. Can't one simply appeal to considerations about benefit and harm? After all, the transfusion is

required to save the child's life regardless of whether (JW) is true. One might also argue that the blood transfusion is necessary to protect the child's right to an open future, since the child may not *have* a future if they don't receive the transfusion.

While these ethical considerations might seem to preserve neutrality concerning (JW), they actually *presuppose* a stance on that belief. Here's why. If (JW) were *true*—if a blood transfusion meant the forfeiture of one's eternal salvation—then it would

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plausibly be obligatory *not* to provide the transfusion. The loss of eternal salvation is plausibly a greater harm than the loss of one's earthly life, and the closing off of this eternal future is more significant than any other. Accordingly, the benefits of the transfusion outweigh its harms *only if* (JW) is false. So, when an ethicist or physician (or perhaps a judge who orders a transfusion) determines that it would be right to override parental refusal in this case, their judgment implicitly depends upon a rejection of (JW) (though the physician may do well not to openly express this).

Something similar can be said for a belief held by some Christian Scientists: medical conditions are, at root, spiritual, and can only be properly addressed through a transformation in one's perception of true spiritual reality. Call this belief (CS). If (CS) were true, then perhaps physicians ought to give up the practice of medicine altogether and convert to Christian Science in order to better treat people. Accordingly, the ethical justification for overriding religiously motivated refusals of care for children must at least implicitly involve a rejection of (CS).

It seems, then, that Brummett is right: in some cases, physicians can't justify overriding religiously motivated refusals without rejecting certain religious beliefs. It's less clear, however, that Brummett's argument calls for a negative verdict on other, more widely held religious beliefs. Consider the religious belief that pain is a means for transforming human character and bringing one closer to God. Call this belief (PT). Brummett maintains that, in order to justify overriding religiously motivated refusals of palliative care for children, physicians must reject (PT). Brummett's reasoning seems to be that, *if* (PT) were true, then to prevent pain would be to prevent God's plan for the spiritual transformation of human character, which would be ethically wrong.

Brummett is mistaken. To see why, consider an analogy from outside of health care. We generally think that power outages should be prevented if possible. But this belief is consistent with the recognition that we can't completely avoid them, and the belief that

when we do experience power outages, they can serve as valuable opportunities to exercise industriousness and patience. Similarly, it's consistent with (PT) to maintain that we should reduce pain when possible, *and* that when we *do* experience pain it can be a valuable opportunity for spiritual growth. For all we know, God might desire both that we help alleviate the suffering of others *and* that any unalleviated suffering we experience would be a means of our spiritual transformation. Consequently, the physician needn't reject (PT) in order to justify overriding parental refusals of palliative care for their children. This is no trivial result, given that (PT) has a millennia-old pedigree in religious thought that provides hope and meaning to those who are suffering.

So, while Brummett is correct about the need for a departure from neutrality on certain religious beliefs, some of his more sweeping claims need to be reined in. But we now face a puzzle: how should we distinguish between religious beliefs that the physician must reject, on the one hand, and religious beliefs on which the physician may reasonably remain neutral, on the other? While an adequate treatment of this question is beyond the scope of this article, I'll close with two tentative suggestions.

First, we can recognize that some religious beliefs can be empirically disconfirmed via data and experiment. (CS) is presumably one such belief. This seems on the right track, since religious beliefs that are empirically disconfirmed *should* be rejected in order to make the clinical judgments necessary for promoting a patient's health. Notice that this criterion still leaves many central religious beliefs intact. For example, no amount of empirical data can disconfirm whether God exists, or whether (if God exists) God might have certain purposes for the suffering we endure.

However, empirical disconfirmation won't function as a sifting mechanism for all of the relevant religious beliefs. This is because there are religious beliefs that we *do* think physicians should reject but that are not open to empirical disconfirmation. (JW)

*See Beliefs on page 7*

## Commentary: The “Futile” Ethics Consultation

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The movie “Princess Bride” is one of the greatest movies of all time. It is a rare day that I am not quoting it at least a few times. One of the best lines is, “[y]ou keep using that word. I do not think it means what you think it means.” Which brings us to the topic of today’s commentary – futility.

The most common reason that I am called for an ethics consultation is for “futility of care.” In general, the ethics literature has moved away from the term, but it still is a common topic in clinical medicine.

As the ethics consultant, I feel it is important to assess what is meant by futility and to not take it at face value.

To define something as futile, or potentially medically ineffective, you need to know: the desired goal or goals, whose goal or goals they are, the desired timeline to achieve said goal/goals, and probability of success given the prior constraints need to be assessed.

What is the goal that is trying to be achieved? Is it a return to health? Is it to some degree of improvement in health? Is it simply to avoid death? This is a very important question and often the first one that I try to clarify. Often this is not defined at all, and the cry of futility is actually frustration or moral distress in caring for a difficult patient or dealing with a difficult situation. If the requester is able to verbalize a goal, it is important to make sure that there are not other goals as well. The disagreement in goals is often a point of contention in the care of a patient. For

example, the treating team may have a goal of the patient being able to return to full function, but the family has a goal of prolonged life.

Once the goal or goals are established, it is important to define who holds which goal. The most important goal to establish is that of the patient, if possible. Ideally the patient would be able to communicate their wishes, but often when these consultations occur this is not possible. An advance directive may be helpful but may not be. An advance directive is often the standard form and if it is a Living Will or Combined Living Will/Medical Power of Attorney, it directs the treating team to discontinue treatment in a terminal condition or in a persistent vegetative state, but often the patient is not truly either of those things. The next best way to obtain what the patient’s goals are is to use substitute decision making (someone that knows what the patient would have wanted in this situation makes the decision as the patient would have made it). Following that we are left with making decisions “in the best interest of the patient.” After the patient’s goals (or best interests) are established, it is important to establish the treating teams’ goals and how these agree or differ.

The desired timelines of the involved parties need to be established. On a long enough or short enough timeline, almost anything becomes impossible.

After the goals and timelines are established, it is important to establish the degree of medical certainty for or against the possibility of success. An important distinction at this point is to make sure that dif-

*See Commentary on page 7*

## ***New York Times* Article Emphasizes the Need for Education and a System to Ensure Patients' End-of-Life Wishes Are Honored**

January 22, 2021 – Paula Span's *New York Times* article ([available here](#)) shares how patients and families can be harmed when a system fails to honor a patient's stated treatment wishes, as documented on a portable medical order called a Physician Orders for Scope of Treatment (POST) in West Virginia, MOLST in New York, and POLST in other states (hereinafter POLST). The umbrella organization is called National POLST and includes 45 states with active programs. ([www.polst.org](http://www.polst.org)). The Greenbergs' tragic experience is one that could have been avoided if Dr. Greenberg's portable medical order had been honored.

Everyone has the right to participate in medical decision-making, and POLST offers one way for seriously ill and frail patients to consider and communicate their treatment preferences.

The critical part of the POLST process is the conversation that takes place between a patient who has a life-limiting condition, their loved ones and their providers. Together, this group makes decisions about preferred treatments, based on the patient's current diagnosis, prognosis and goals. The patient's decisions are then documented on a POLST form. The patient's wishes, translated into medical orders, are then clear to emergency responders or other health care providers. What is clear from the cases in the *New York Times* article is that a good conversation and clear documentation are NOT enough.

Every health care system must also have systems in place that enable providers to easily see if a patient has a POLST form in the electronic medical record (EMR) or in a statewide registry such as the West Virginia e-Directive Registry, <http://wvendofoflife.org/wv-e-directive-registry/>. Under West Virginia law, health care providers are required to follow the patient's treatment wishes documented in the West Virginia POST form.

It is regrettable that it took a lawsuit for Dr. Greenberg's treatment wishes to be belatedly recognized,

but if this and similar lawsuits end up clarifying the importance of honoring POLST orders, then patients and their loved ones will benefit tremendously.

There are **four key lessons** from the case of Dr. Greenberg and the others in the *New York Times* article:

1. Patients need to have conversations with their family and with their treating health care provider in which they express their values, wishes, and goals.
2. Patients' wishes need to be documented clearly and accurately in advance directives and POLST forms.
3. Advance directives and POLST forms need to be accessible during medical emergencies in hospital EMRs and in statewide registries.
4. Health care providers and systems need to understand their legal requirements to honor those wishes.

Fortunately, we have just such a system in West Virginia. For more information about the West Virginia POST form, the West Virginia e-Directive Registry, or the law regarding POST use, visit [www.wvendofoflife.org](http://www.wvendofoflife.org) or call 877.209.8086.

**About POLST:** POLST is an approach to advance care planning for patients who are considered to be at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty. The POLST process emphasizes eliciting, documenting and honoring patients' preferences about the treatments they want to receive during a medical emergency or as they decline in health. At the end of the process, a health care professional may document these treatment preferences in a portable medical order called a POLST form. POLST forms must be completed by health care professionals and signed by a physician, advanced practiced registered nurse or physician assistant in line within their scope of practice and state law. Learn more at [www.polst.org](http://www.polst.org)

# Test Your Knowledge Questions: Conflict about Honoring Patient's Expressed Directives



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**Case from the American Society of Bioethics and Humanities:** A 71-year-old woman is hospitalized in the ICU with acute respiratory failure requiring mechanical ventilation and sedation. She has a long history of COPD and is on oxygen 24 hours per day. In addition she has peripheral vascular disease and stable angina pectoris.

She was admitted a week ago for mild respiratory distress. In conversation with her husband and the physician during that admission, she voiced that she did not want life support treatment, including intubation, due to her poor quality of life. The physician documented the decision and placed a do-not-attempt-resuscitation (DNAR) order in the hospital chart. She was subsequently discharged home with no order in force limiting treatment.

Today when she developed trouble breathing at home and passed out, her husband called 911 and insisted that the paramedics intubate her on arrival to their home. The paramedics complied with the request. Now in the ICU, her husband is insisting that she continue to receive aggressive life-sustaining treatment. The patient does not have decisional capacity.

The medical team calls for an ethics consult, requesting support for the continuation of the DNAR.

Please answer the following three questions about the case.

## Question #1

**What is the underlying ethical standard guiding the HEC analysis of this case?**

- A. Best Interests
- B. Surrogate decision-making
- C. Beneficence
- D. Substituted judgment

## Question #2

**What should the HEC do first?**

- A. Ensure that a DNAR order is in effect so that the patient will not receive inappropriate CPR if she decompensates.
- B. Obtain a copy of the advance directive signed during the last admission to justify continuing the DNAR order.
- C. Meet with the patient's husband to determine why he objects to the DNAR order.
- D. Recommend discontinuation of life-sustaining treatment as the patient did not want to be intubated in the first place.

## Question #3

**In response to the request for the consult, what should the HEC do?**

- A. Inform the medical team that an ethics consult is not indicated, as it not required to enforce a legally documented DNAR.
- B. Redirect the medical team to the hospital's administration and legal counsel, as they would be more appropriate to lend institutional support the DNAR order.
- C. Discuss the reason for an ethics consult with the medical team and set reasonable expectations for the consult.
- D. Support the medical team's view that a DNAR is appropriate in this situation and that continuation of life support is inappropriate in this situation.

## RESPONSE

Before looking at the questions, let's examine what is going on in this case. Remember that this is a hypothetical case. I will put it in the context of patient care in West Virginia. The patient expressed her wishes not to have CPR and be intubated in the first hospitalization. Unfortunately, a Physician Orders for Scope of Treatment (POST) form with orders to

this effect were not given to her at the time of discharge so when 911 was called and the paramedics responded, they had no legally valid outpatient medical orders to guide them.

The patient had passed out and lacked decision-making capacity. She could not object to intubation. In the hospital, the husband is persisting in requesting treatment that the patient had previously stated she did not want. The treating ICU team knows that the husband's request is contrary to the patient's wishes from the medical record of the previous hospitalization.

West Virginia law [the West Virginia Health Care Decisions Act, §16-30-5(b)] stipulates that the patient's prior expressed directives are to be followed if there is conflict between the patient's directives and the medical power of attorney representative or health care surrogate.

“(b) If there is a conflict between the person's expressed directives, the physician orders for scope of treatment form and the decisions of the medical power of attorney representative or surrogate, the person's expressed directives shall be followed.”

In this case, we have information from the first hospitalization about the patient's prior expressed directive to guide decisions for her. **The correct answer to #1 is D.** Substituted judgment. Substituted judgment is when a legally authorized representative (in West Virginia, it could be a medical power of attorney representative or health care surrogate) for a patient who lacks decision-making capacity makes a decision for that patient based on knowledge of what the patient would have decided if she had the capacity to do so.

Since the husband is requesting treatment contrary to the patient's known wishes based on her previous hospitalization, the first step is to meet with the husband and find out why. Did the wife change her mind once she left the hospital and indicate she would be willing to be intubated again? **The correct answer for #2 is C.**

With regard to #3, it is good practice to meet with the person requesting the ethics consult to learn his/her question and additional information about the case and consult request. **The correct answer for #3 is C.**

If the ethics consultant meets with the husband and learns that the patient had not changed her mind, then as a result of the process, the ethics consultant would recommend to reinstate the DNAR order and extubate her based on the ethical principle of respect for patient autonomy and West Virginia law. It could be that the husband was not ready to lose his wife and that was the reason for his request. If so, the ethics consultant might also recommend psychosocial and spiritual support for the husband.

If the husband reports that the patient had changed her mind, it would be important to find out what she said, why she said it, and to whom she said it. The ethics consultant also would want to inquire whether the patient completed an advance directive and/or POST form after the hospitalization. This information will be important to determine if intubation and a full code status are appropriate for the patient at this point based on her most recently expressed wishes.

This case requires knowledge of ethical principles, decision-making capacity, ethical decision-making for patients who lack decision-making capacity, substituted judgment, and the ethics consultation process. An evaluation of the care in this case would identify failure to discharge the patient with a POST form with DNR and limited additional treatment orders as a medical error. It is also not clear to what extent the husband was educated during the first hospitalization about the ethics and law of respecting his wife's wishes.

The above sample questions and additional ones with answers to prepare to take the Healthcare Ethics Consultant Certification Examination can be found here: <https://heccertification.org/preparation/sample-questions>.

If you have comments or questions about this case, the answers, or the response, please write to Linda McMillen, [lmcmillen@hsc.wvu.edu](mailto:lmcmillen@hsc.wvu.edu).

is one such example (since there is no empirical method to discern the prerequisites for eternal salvation). On what grounds, then, can the physician reasonably reject beliefs like (JW) in order to justify overriding religiously motivated refusals? It's tempting to simply dismiss the belief on the grounds that we have an obligation to promote a patient's best interest. But again, this won't do, since what the patient's best interest is depends upon whether the religious belief in question is true.

In the end, it looks as though clinical ethicists and physicians may need to adopt a stance on certain metaphysical questions—even if it's a negative stance. Given the importance of respecting autonomy and the diversity of religious belief, overriding religiously motivated refusals is a very serious matter and should not be taken lightly. There will, however, be some cases where doing so may be necessary—at least as a last resort, and when a child's life is in imminent danger. The ethical judgements made to override religiously motivated refusals in these specific cases require adopting a position on the rational plausibility of beliefs concerning the existence and nature of the supernatural. This leads us into the realms of philosophy and spirituality. Does this mean that clinical ethicists and physicians must engage in philosophical and spiritual reasoning in order to justify overriding religiously motivated refusals? Perhaps I am mistaken, but I'm not sure I see an alternative.

References:

<sup>1</sup>Woolley, S. 2005. Children of Jehovah's Witnesses and adolescent Jehovah's Witnesses: what are their rights? Archives of Disease in Childhood 90 (7):715–9.

<sup>2</sup>Schuklenk, U. 2019. Conscience-based refusal of patient care in medicine: A consequentialist analysis. Theoretical Medicine and Bioethics 40 (6):523–16.

<sup>3</sup>Bester, J. C. 2018. The harm principle cannot replace the best interest standard: Problems with using the harm principle for medical decision making for children. The American Journal of Bioethics: AJOB 18 (8):9–19.

<sup>4</sup>Brummett, A. 2020. Secular clinical ethicists should not be neutral toward all religious beliefs: An argument for a moral-metaphysical proceduralism. The American Journal of Bioethics.

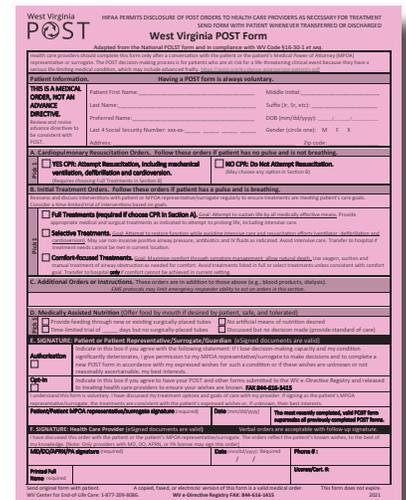
ficult is not confused with impossible. Setting what probability constitutes futile is a large driver of why futility has been abandoned in the ethical literature.

At this point, the goals of the patient and the clinicians may be at odds or the probabilities are uncertain. Occasionally, the ethics consultant can swoop in with a decisive recommendation. The reality is that further communication between the treating teams and the patient/ surrogate with a goal to negotiate a reasonable treatment plan is often needed.

### The NEW West Virginia POST Is Available

Published in 2021, the new West Virginia POST is adapted from the National POLST (<https://polst.org/national-form/>) yet in compliance with West Virginia health care law. Health care providers should complete this form only after a conversation with the patient or the patient's Medical Power of Attorney representative or surrogate regarding their treatment values and preferences. The POST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty. (<https://polst.org/wp-content/uploads/2020/04/2020.04-Form-Guidance.pdf>).

If the patient has an advance directive, health care providers should review it when completing a POST to be sure that the patient's advance directive and the orders on the POST are consistent. If need be, the advance directive may need to be updated. Usually as patients' chronic medical conditions worsen, patients want less medical intervention. After completion of a POST, health care providers should encourage patients to opt-in to submission of the POST to the West Virginia e-Directive Registry so that the form will be available to treating health care providers in an emergency. The Registry FAX number is 844-616-1415.



## CALENDAR OF EVENTS

### WVNEC Noon Webinars

**March 17, 2021** - WVNEC Noon Webinar, *“Goal-concordant care: Why should it be our highest priority?”* This webinar will explore the topic of goal-concordant care in discussing a case recently highlighted in the Boston Globe, “Hospital staff revived a man’s stopped heart—and he sued.” Panelists will include an attorney, an ethicist, and an advance care planning specialist.

**June 16, 2021** - WVNEC Noon Webinar, *Moral Distress: The ICU Team was Divided Over the Right Thing to Do for John*

The webinars will be **FREE** to the first 100 registrants on a first-come first-serve basis. No continuing education credits or certificates will be provided for these webinars.

### 33rd Annual WVNEC Symposium

**May 5, 2021** - *“The Latest in Ethics Consultation and Advance Care Planning: National Perspectives”* - This program will be a half-day virtual symposium. Additional information and cost will be posted on our website at a later date.

Visit our website at [www.wvnec.org](http://www.wvnec.org) for the latest information on future events.

## CALLING ALL WRITERS!

We are always looking for interesting ethics topics, cases, and perspectives to share with our WVNEC Newsletter readers. If you would like to contribute by sharing your difficult cases, suggesting an idea for an article, or WRITING an article, please consider doing so. Anyone in a health related field, or who has interacted with the healthcare community, can submit ideas or article to be considered for inclusion in the newsletter. Also, we would like to provide students with an opportunity to have their voices heard in the “Student Corner” section of the newsletter. If you know of or work with a student(s) who may be interested in ethics and would like to write for the newsletter, please encourage them to reach out to us. We’d be delighted to give the future of healthcare a vehicle to share their perspectives. To inquire about any of these opportunities please contact Linda McMillen at 304-293-7618 or [lmcmillen@hsc.wvu.edu](mailto:lmcmillen@hsc.wvu.edu).



**Mission Statement:** The West Virginia Network of Ethics Committees assists hospitals, nursing homes, hospices, and home health care agencies to strengthen ethics committees; provides education regarding ethical and legal issues in health care to promote ethically sound decision-making; and helps patients and families to make their end-of-life wishes known.

This is a quarterly publication of the Center for Health Ethics and Law, Health Sciences Center of WVU, for the West Virginia Network of Ethics Committees. Questions, comments, and ideas should be submitted to:

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