Case Report

Conscientious objection to enforcing living wills: A conflict between beneficence and autonomy and a solution from Indian philosophy

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Living wills document how patients wish to be treated in the event of becoming incompetent to make their medical decisions. Living wills are legally enforceable in India, nonetheless, doctors can claim conscientious objection to implementing any aspect of such directives; however, the buck stops with the hospital to ensure that the patient's wishes are carried out. In enforcing advance care directives, beneficence and autonomy usually come into conflict. In a paternalistic model of medicine, beneficence and nonmaleficence take precedence over autonomy, and there is a danger that the patient's wishes are ignored. Even if a physician is not trained to give equal importance to autonomy, beneficence, and nonmaleficence, they can rationalize the enforcement of an advance care directive under the principle of nonmaleficence rather than under autonomy. The ethical principles of ahimsa—the principle of not being the cause of physical or mental injury of others—and raja dharma—the principle where a person in a position of power puts the wishes of the person whom they have power over ahead of their own wishes—which are derived from Hindu, Buddhist, and Jain philosophical traditions, can help physicians who practice Indic faiths resolve their moral dilemma when faced with a possibility of enforcing a patient's wishes that are not in line with their personal views. Such moralizing is especially important during public health emergencies when a patient may not be able to transfer to the care of another doctor who does not have an objection to enforcing their living will.

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 doi.org/10.32388/FUZZHG

Introduction

An advance care directive documents the wishes of the patient in terms of the treatments the patient wishes to receive in the event of his or her becoming unable to make their medical decisions (Campbell & Kisely, 2009). These directives are to be written by the patient after consultation with their family and physician. Although considered an essential component of end-of-life care, given that emergencies can befall anyone at any time, advance care directives are important for everyone notwithstanding their current condition. Autonomy is the foundational ethical principle of advance care directives (Wilkinson et al., 2007).

In its landmark 2018 judgement in Common Cause v. Union of India, the Supreme Court of India deemed the right to die with dignity— which includes the right to a dignified life up to the end of natural life, the right to refuse medical treatment, and the right to make an advance directive or living will, and excludes the right to die arbitrarily or at the hands of another person, and euthanasia and assisted suicide—an inalienable part of Article 21 of the Indian Constitution, and legalised advance care directives in India (*Common cause vs. Union of India*, 2019). Thenceforth, a person above the age of 18 years is able to issue an advance care directive regarding the manner and extent of medical treatment given to them in case they become incapacitated to make an informed choice. The advance care directive is called the "living will" in India.

Ethics is an inalienable aspect of clinical practice; the physician is ethically obligated to do right by the patient, minimize harm, and respect their values and preferences. Each of the four principles of bioethics (beneficence, nonmaleficence, autonomy, and justice) must be fulfilled at all times during clinical practice, unless one principle conflicts with another—in such instances, the physician is required to determine the weights of the competing ethical obligations based on the context, and act accordingly. Conflicts between beneficence and autonomy are frequent and prominent. Beneficence and nonmaleficence have underpinned traditional medical practice, tracing back to the Hippocratic oath; giving them primacy over autonomy results in paternalism, which is prevalent in medical practice (Varkey, 2021).

Bioethics, like all applied ethics, vary with culture (DuBose et al., 1994). Therefore, it is important to examine the tenets of bioethics defined and practiced for ages in India, in order to understand better the equation between beneficence and autonomy in the Indian context. A cursory survey of classical texts of Ayurveda, the traditional system of medicine in India, reveals that the physician dictates the course of the

treatment. Sushruta Samhita, one of the fundamental texts of Ayurveda, says that patients should surrender themselves to their doctors (Wujastyk, 2012). The physician determines what is best for the patient, neither the patient nor their family have a say in it (Wujastyk, 2012). Preference is conferred to the physician whether to tell the truth to the patient or not (Wujastyk, 2012). The doctor is allowed to conceal information, mislead and even lie to the patient in the interest of better treatment of the patient (Wujastyk, 2012). The 'means are justified by the ends' approach is a clear expression of paternal beneficence in Ayurveda. Although Ayurvedic ethics instruct the physician to speak truthfully, among other things, Charaka Samhita, another fundamental text of Ayurveda, suggests that as truth may cause further suffering to the patient, 'speaking truthfully' is not absolute (Wujastyk, 2012). Moreover, it is the physician who decides whether a particular information would further harm a patient or not (Wujastyk, 2012). Evidently, the ethical framework of Ayurveda bluntly advocates a paternal doctor–patient relationship. Given the longstanding tradition of Ayurveda and its influence on what is considered an acceptable doctor–patient relationship in Indian society, it is not surprising that medical ethics in India have continued to be heavily skewed in favour of beneficence, while undermining autonomy.

Nevertheless, there has been a recent shift towards patient-centred care, with procedural justice (all stakeholders are to be heard, and all options are to be discussed openly during the decision-making process) and autonomy treated as equally important to beneficence and nonmaleficence (Odell et al., 2014). However, a move towards this shift has started to occur in India only recently, with the advent of digital health where patients are able to publicly rate their doctors on the internet; how the patient feels during the doctor–patient interaction influences the rating, and the rating may influence which doctors a new patient chooses to consult. Nevertheless, given that the penetration of digital health is not very high, medical practice remains largely paternalistic in India.

When the principle of beneficence and the religious beliefs of the physician converge, the principle of autonomy can become a casualty, particularly in a paternalistic medical setting. One such instance is detailed herein.

The context

During the coronavirus disease (COVID-19) pandemic, the Samanjasa Foundation, Chennai, India had engaged a panel comprising theologians of different faiths, a philosopher, a lawyer, and a medical social scientist to help resolve any ethical dilemmas for frontline healthcare workers. A physician who

identified as Hindu sought the support of the panel to address an ethical dilemma arising from a particular case in May, 2021 during the peak of the Delta wave of the COVID-19 pandemic in India.

The case

The publication of the case was approved by Sri Jagannath Healthcare and Research Center - Independent Ethics Committee (approval number SJHRC–NI/21/OCT/16). During the peak of the Delta wave of the coronavirus disease (COVID-19) pandemic in India, an 89-year-old patient with a living will stipulating that in case of deterioration, the patient agrees to receive all measures except resuscitation and mechanical ventilation contracted COVID-19 and was admitted to the COVID-19 ICU of a tertiary hospital. The existence of the living will was not disclosed to the ICU physician or the hospital management at the time of admission.

After ICU admission, the patient stabilised over one week and then deteriorated again. The treating physician informed the patient's family that she may require mechanical ventilation in case of further deterioration. At this time, the patient's family informed the treating physician regarding the patient's wishes of not receiving mechanical ventilation and shared a copy of the living will. The treating physician then told the patient's family that she will not be able to stop providing life prolonging therapy in case the patient deteriorates, as that goes against her religious beliefs. The patient's family then requested that another physician be assigned the charge of the patient so that they can carry out her wishes. An appointment was made with another physician working at the same ICU, and the patient's wishes were discussed. The second physician also advised the patient's family of his inability to carry out the patient's wishes due to religious reasons. The hospital management then informed the patient's family that only two physicians handled the COVID-19 ICU at the hospital, and because both doctors claimed conscientious objection to enforcing the patient's will, and because they cannot be forced to enforce the patient's wishes as per Article 25 of the Constitution of India, the patient's family must consider shifting the patient to another facility where their wishes can be honoured. The patient's family was unable to shift the patient to another hospital as no beds with oxygen facility were available throughout the city, and the same was communicated to the hospital management.

According to *Common cause vs. Union of India*, 2019, it is the responsibility of the healthcare institution to ensure that the patient's autonomy is respected, while accommodating the physicians' conscientious objections to the best extent possible. This usually involves finding another physician in the same facility who is willing to execute the living will or transferring the patient to another facility where the living will

can be executed. However, in this case, due to the COVID-19 pandemic, both options were unavailable. Under normal circumstances, the hospital management would have asked another physician affiliated with it to takeover the case; however, during the COVID-19 pandemic, to facilitate infection control, the hospital set up a separate COVID-19 ICU and restricted access to it to only certain members of its staff; doctors who were not working in the COVID-19 ICU could only be consulted over the telephone—they could not takeover care of patients in the COVID-19 ICU as they had never examined them. In this case, both physicians assigned to the COVID-19 ICU had claimed conscientious objection and so, the only option was to shift the patient to another facility. However, even this could not be done due to strain on the health system owing to the Delta wave of the COVID-19 pandemic, which led to a shortage of hospital beds with oxygen facility at that time. Under these circumstances, the hospital encouraged the treating physician to seek the support of the panel constituted by the Samanjasa Foundation. As the physician identified as a Hindu, she was invited to deliberate with the Hindu theologian on the panel, along with the philosopher and social scientist via videoconferencing, and supported in her decision-making. An overview of the deliberations is provided in the next section.

Bioethics from an Indian philosophical point of view

Conscientious objection arises when a physician's views on how best to pursue beneficence and nonmaleficence differs from their patient's views (Sine & Sharpe, 2011), and the principles of beneficence and nonmaleficence weigh higher than the principle of autonomy. Even in a paternalistic model of medicine where beneficence and nonmaleficence take precedence over autonomy, physicians can respect a patient's living will under the ethical principle of nonmaleficence. Ignoring a living will can lead to significant physical distress to the patient in the form of broken ribs and/or sternum, or injury to internal organs including the brain, during cardiopulmonary resuscitation or other invasive measures (Darok, 2004). Ignoring the patient's wishes may also lead to mental distress due to loss of autonomy, or because of having to live with a lower quality of life than the patient is willing to endure due to the injuries sustained as a result of invasive measures (Lynch et al., 2008). These are significant harms to the patient, and the physician is obligated to do no harm. Keeping these harms and the principle of nonmaleficence in mind, the physician can rationalize enforcing a living will even if the physician is not trained to give equal importance to the principle of autonomy.

Because socio-cultural beliefs influence bioethics (Tsai, 1999), it is reasonable to propose culture-specific resolutions to the ethical conflicts between the principles of beneficence and autonomy. The ethical

reflections in Indian philosophy can be utilized to mitigate such ethical challenges confronted by the Indian medical fraternity. The Acharanga Sutra, the first of the twelve sacred religious texts of Jainism, states that sorrow or pain is undesirable to every living being and hence, anything that lives, that exists, that breathes, or that has any essence of life, should not be subjugated or harmed physically or mentally, as either of them can cause pain (Bothra, 2004). This ethical principle follows from Ahimsa (non-violence), one of the five vows to be followed in the path of Dharma (righteousness), and ahimsa in Jainism not only refers to not hurting any living creature physically but also to not causing emotional suffering to others (Jainism – Ron Huntington, n.d.). Moreover, ahimsa is also the first of the five precepts of Buddhism (Tribe et al., 2000). Not being able to get what one wishes causes one of the three types of sufferings defined in Buddhist philosophy (Tribe et al., 2000), and subjecting a living being to suffering is a violation of ahimsa. Ahimsa is also highlighted as one of the 26 ethical principles, in the sixteenth chapter of the holy Bhagavad Gita (BG), an ancient Hindu scripture. Here, ahimsa refers to non-injury, i.e., abstaining from being the source suffering of other living beings (16, p. 121, 153, 179). Daya, which refers to being unable to stand the misery of other living beings, is also one of the 26 ethical principles (BG 16.2). BG also advocates observing mardavam (BG 16.2), i.e., not being harsh, cruel, or insensitive towards others' feelings, and explicitly prohibits paurushyam (BG 16.4), which means being rude or the cause of suffering to others (Bhāṣya & Rāmānujācārya, 2013, p. 180). Thus, the ethical principle of ahimsa, as outlined in Jain, Buddhist, and Hindu philosophical traditions, requires that individuals not be subjected to unwanted and avoidable physical and/or emotional pain; and not enforcing the patient's advanced care directives can lead to physical and/or emotional pain as mentioned above.

However, enforcing a patient's advanced care directives without consideration for the physician's own views is not advisable, as the physician is subjected to emotional pain by having to act against their conscience. Acting as per one's own conscience, referred to as the concept of swadharma (Narayan, 2004) is important to avoid swahimsa, i.e., inflicting injury on oneself, which is in turn regarded as a violation of ahimsa. The concept of raja dharma can aid in mitigating the physician's distress. Raja dharma refers to the duties of a ruler towards his/her subjects (Rastogi, 2018). In modern times, where kings no longer hold power and democracy is the dominant system of governance, raja dharma applies to government servants, politicians, and others in positions of power over others.

Although the following main differences between the doctor–patient relationship and the king–subject relationship exist:

- the doctor–patient relationship is generally viewed as a voluntary agreement between two individuals, while the king–subject relationship is usually based on inherited or acquired power,
- in the doctor–patient relationship, the doctor's duty is to act in the best interests of the patient, whereas in the king–subject relationship, the king's duty is to act in the best interests of the kingdom or the state, and
- the doctor–patient relationship involves the patient's consent to medical treatment, whereas the king–subject relationship does not necessarily involve the subject's consent to the king's actions,

we deem that Raja dharma is relevant to medical ethics because of the following similarities in the doctor–patient relationship and the king–subject relationship:

- both relationships involve a power differential, and one party (physician or king) has a certain amount of authority and control over the other party (patient or subject). In the case of a physician, they have expertise and knowledge that the patient lacks, while in the case of a king, they have political power that the subject lacks;
- both relationships involve a duty of care, where the party in power has a responsibility to act in the best interests of the other party. In the case of a physician, this involves providing medical care and advice that is in the best interests of the patient. In the case of a king, this involves providing governance and protection that is in the best interests of the subject;
- both relationships require trust between the parties. Patients must trust their physicians to act in their best interests and provide them with the best possible care. Subjects must trust their kings to act in their best interests and govern them justly.

Understanding the dynamic between raja dharma and swadharma is key to resolving the moral dilemma that a doctor faces whenever they are torn between implementing the living will of the patient and saving the life of the patient, which they consider their swadharma. In the Ramayana, one of the two major epics of ancient India, King Rama prioritizes raja dharma over his swadharma when he banishes his wife Sita from his kingdom as the citizens were suspicious of her loyalty to Rama during her captivity in the kingdom of Lanka ruled by Ravana, and had asked him to disown her. Rama tries his best to convince his citizens and when they fail to be convinced, he even decides to forsake the throne and live in the forest with Sita. However, due to a lack of a willing successor to the throne, and as raja dharma dictates that the king must ensure a suitable successor before forsaking the throne, he is forced to continue as king, and follow the rules of raja dharma which also dictate that the king must behave in

such a way that no citizen is subjected to physical or mental agony due to the actions of the king, even if it means the king has to commit swahimsa. Despite great personal agony, Rama is forced to banish Sita from the kingdom. At a personal level, Rama's stand is different and much more liberal, which is reflected in the fifth chapter of Bala Kanda of the Ramayana, when Rama as a prince chooses to forgive Ahalya, who was cursed by sage Gautama for committing adultery, and liberates her from the curse. Rama, having an astute awareness of Dharma, knows that even if his personal opinion differs from the collective opinion of the society of his times, he must give precedence to raja dharma over all other dharmas, at all times. Being an upholder of dharma, he chooses to honour the wishes of his subjects irrespective of his personal point of view. In Mahabharata, the other major epic of India apart from Ramayana, raja dharma is hailed as the foremost of all dharmas (Shanti Parva 63.25). The Arthashastra, another ancient Indian scripture, promotes the idea of honouring the wishes of the subjects, as one of its central themes. It says that happiness and benefits of the subjects take precedence over the happiness and benefits of the ruler (1.19.34).

Thus, Rama's choice of action stands justified. Furthermore, the Tirukkural, which is a Classical Tamil text compiled by Thiruvalluvar, states that the benefactor puts an end to his/her own suffering by taking appropriate action to put a smile on the help-seeker's face as he/she can't bear the pleader's pain (Kural 224), i.e., one should feel the help-seeker's plight as one's own and instead of simply sympathizing, one should act accordingly to restore happiness to the pleader. Kural 315 asks what is the use of one's knowledge, if one cannot understand the woes of others and strive to fend off their pain, as much as one would strive to fend off one's own pain. The Tirukkural also states that those who possess love always care for others more than they care for themselves; whereas, persons who are loveless are selfish and think about themselves and their own wishes ahead of those of others (Kural 72). Thus, according to Indian philosophical thought, those in positions of power are required to put the welfare of others ahead of their own welfare. This line of argument can be extended by doctors to justify the implementation of living wills against their own personal preferences.

By prioritizing raja dharma, i.e., upholding the will the patient over whom they hold power, instead of swadharma, i.e., upholding what they believe at a personal level, a doctor can reconcile their moral conscience that comes in the way of implementing living wills. This is particularly useful in the face of a public health emergency, where it may not be possible for a patient to seek another doctor to manage their condition, and the physician has a conscientious objection to managing the patient according to their will.

Conclusion

The physicians must be sensitized with the principles of ethical conduct so that they can comprehend that by denying the wishes of the patient, they are causing suffering to the patient, and thus committing unintentional violence. The doctor–patient relationship is similar to the ruler–subject relationship, and teaching ethics from the Indian philosophical standpoint may help the doctors who practice Indic religions whenever they find themselves morally conflicted at the crossroads of beneficence and autonomy. This will substantially shift the balance towards the principles of autonomy and justice, as against the principles of beneficence and nonmaleficence, whenever the physician is stuck in a moral dilemma.

Statements and Declarations

Funding

No funding was received for conducting this study.

Competing interests

The authors have no competing interests to declare that are relevant to the content of this article.

Compliance with Ethical Standards

The patient and the next of kin referred to in this case study provided informed consent to publish.

Ethics approval was obtained from "SRI JAGANNATH HEALTHCARE AND RESEARCH CENTER - INDEPENDENT ETHICS COMMITTEE", REF no: SJHRC – NI/21/OCT/16

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Declarations

Funding: No specific funding was received for this work.

Potential competing interests: No potential competing interests to declare.