

When Is Overriding a Patient's Treatment Refusal Ethically Defensible? A Systematic Review of Normative Arguments Concerning Capacity, Preventable Harm, and Professional Obligations in Adult Clinical Care

Sarah Bennett¹, David Thompson^{2*}, Emily Carter³, Michael Lee⁴

¹Department of Bioethics, University of Manchester, Manchester, United Kingdom

²Department of Clinical Ethics, University of British Columbia, Vancouver, Canada.

³Department of Health Law and Ethics, McGill University, Montreal, Canada.

⁴Department of Philosophy, University of Toronto, Toronto, Canada

*E-mail ✉ david.thompson@ubc.ca

Abstract

Adult treatment refusal can place respect for autonomy in tension with duties to prevent serious harm. The ethical problem is not resolved by labeling a refusal unwise because decisional authority, authenticity, professional obligation, proportionality, and the burdens of treatment over objection may diverge. To systematically identify, appraise, and synthesize normative arguments concerning when overriding an adult patient's treatment refusal can be ethically defensible. Reproducible PubMed-domain searches and supplementary verification/citation-chaining routes covered 2018–2026. Eligible reports contained reconstructable arguments about adult treatment refusal or a necessary justificatory premise. Arguments were appraised for conclusion clarity, premise transparency, inferential connection, engagement with objections, and contextual boundaries. PRISMA 2020 guided reporting. Eighty-two records were identified; seven duplicates were removed and 75 unique records were screened. Thirty-two were excluded at screening, 43 reports were sought, four were not retrieved, 39 were assessed, nine were excluded, and 30 normative evidence units were included. Six recurrent argument families concerned decisional authority, preventable harm, authenticity and values, professional obligations, proportionality, and contextual exceptions. The literature supports a conditional approach. Override is most defensible when decisional authority is materially compromised, serious preventable harm is likely, treatment offers proportionate benefit, less restrictive responses are inadequate or infeasible, and coercive burdens do not defeat the justification.

Keywords: Treatment refusal, Decision-making capacity, Autonomy, Treatment over objection, Proportionality, Clinical ethics

Introduction

An adult patient's refusal of treatment ordinarily carries substantial moral force, yet clinicians sometimes confront refusals that appear likely to result in serious and preventable harm. Recent evidence suggests that refusal itself may trigger greater scrutiny of decision-making capacity, raising the danger that disagreement

with medical advice is treated as evidence of impaired authority [1]. Acute opioid-overdose care illustrates the difficulty: after reversal, a patient may communicate a refusal while clinicians remain uncertain about residual impairment, recurrent toxicity, and the consequences of departure [2]. The same decision can therefore engage autonomy, rescue, non-maleficence, and professional accountability.

Capacity is central but contested. Authenticity-based accounts ask whether a decision adequately expresses the patient's own values rather than merely satisfying cognitive criteria [3]. Institutional status can also obscure the issue: an involuntary psychiatric hold does not by itself settle whether clinicians may override refusal of a particular intervention [4]. The relevant distinction is therefore among incapacity, unusual values, difficult

Access this article online

<https://smerpub.com/>

Received: 24 July 2026; Accepted: 28 September 2026

Copyright CC BY-NC-SA 4.0

How to cite this article: Bennett S, Thompson D, Carter E, Lee M. When Is Overriding a Patient's Treatment Refusal Ethically Defensible? A Systematic Review of Normative Arguments Concerning Capacity, Preventable Harm, and Professional Obligations in Adult Clinical Care. *Asian J Ethics Health Med.* 2026;6(2):159-68. <https://doi.org/10.51847/CejDMT8DT8>

behavior, disagreement, and a choice whose consequences clinicians regard as unacceptable.

Refusal of basic care makes the conflict especially visible. Analyses describe collisions among autonomy, dignity, beneficence, and duties to prevent foreseeable deterioration [5]. Legal-ethical commentary likewise stresses that hospitalization is not blanket authority to impose treatment on a patient who retains decisional authority [6]. These positions leave room for emergencies and professional duties, but they demand an account of what additional conditions can justify treatment over objection.

This review asks how normative literature from 2018–2026 structures arguments for and against overriding an adult patient's own treatment refusal, where those arguments converge or conflict, and which contextual conditions alter their force. It reconstructs six domains—decisional authority, preventable harm, authenticity and values, professional obligation, proportionality, and exception conditions—without treating argument frequency as evidence of ethical correctness. Family substitution, disclosure, advance-care planning, and culturally mediated decision making are considered only when they directly illuminate the authority or proportionality of overriding the patient's refusal.

Materials and Methods

This systematic review of normative arguments used PRISMA 2020 to report identification, deduplication, screening, retrieval, eligibility assessment, and inclusion [7]. Methodologically, it drew on precedent for systematic analysis of argument-based ethics literature [8]. Systematicity here concerns transparent retrieval and selection; it does not convert the numerical prevalence of an argument into normative authority, a problem specifically identified in methodological critiques of systematic reviewing in bioethics [9].

Five PubMed-domain search batches were executed on 22 September 2026 for literature published from 2018–2026. Search logic combined terms for treatment refusal, refusal of care, decision-making capacity or competence, autonomy, beneficence, harm, proportionality, coercion, paternalism, treatment over objection, and professional obligation, supplemented by journal-targeted searches in medical ethics and bioethics. Publisher searches were used only for bibliographic verification and were not added to the identification denominator. Eighty-two records were retrieved; seven duplicate occurrences were removed by title plus DOI/PMID matching, leaving 75 unique records. Thirty-two were excluded at title/abstract screening. Forty-three reports were sought, four were not retrieved to the required report-level representation, 39 were assessed, nine were excluded, and 30 normative evidence units were included.

The executed selection process is shown in **Figure 1**.

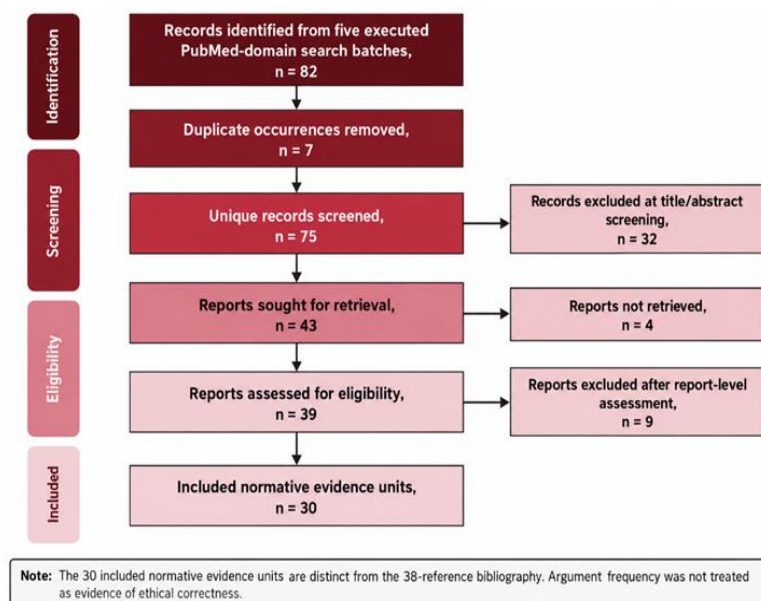


Figure 1. PRISMA flow diagram

Eligible reports contained at least one reconstructable argument materially relevant to overriding, respecting,

evaluating, or responding to an adult patient's own treatment refusal, or to a necessary premise concerning

capacity, autonomy, preventable harm, professional obligation, proportionality, permissible influence, or treatment over objection. Pediatric or parental refusal, clinician conscientious refusal, research consent, surrogate decision making without a direct bridge to adult refusal, and reports lacking a reconstructable normative premise were excluded. Journal quartile was not an eligibility criterion.

Each argument was appraised qualitatively for conclusion clarity, premise transparency, inferential connection, engagement with objections, and specification of clinical, legal, temporal, institutional, or population boundaries. No numerical quality score was used. Synthesis first reconstructed recurrent argument

families and then compared their premises, counterarguments, defeaters, and conditions. Particular attention was paid to whether harm was treated as evidence of incapacity or as a separate reason for intervention; whether professional obligation required support, reassessment, consultation, or override; and whether urgency, reversibility, diagnosis, institutional authority, or coercive burden changed the justification. Quantitative pooling was inappropriate because the evidence units were normative arguments rather than commensurable effect estimates.

The organizing families are summarized in **Table 1**. They structure extraction and synthesis but do not rank ethical importance.

Table 1. Argument families used to reconstruct justifications for and against overriding adult treatment refusal

Argument family	Core question	Main justificatory role	Boundary that must remain visible
Decisional authority	Does the patient retain authority over this decision?	Establishes the presumptive force of refusal	Refusal, diagnosis, or disagreement alone does not establish incapacity
Preventable harm	What serious harm follows if refusal is respected?	Generates protective reasons	Harm and decisional authority are distinct
Authenticity, values, affect, rationality	Does the choice express the patient's evaluative standpoint?	Tests cognition-only accounts	Unusual values do not themselves erase authority
Professional obligations	What must clinicians do when refusal appears dangerous?	Supports information, support, reassessment, consultation, and protection	Duty to care is not automatically authority to compel
Proportionality	Would treatment over objection justify its burdens?	Tests benefit, urgency, efficacy, force, trauma, and feasibility	Incapacity alone may leave coercion disproportionate
Exceptions and context	Which circumstances alter the other arguments?	Modifies urgency, authority, feasibility, or risk	Context-specific exceptions must not become general rules

Results and Discussion

Thirty normative evidence units met the eligibility criteria. The literature did not converge on a single rule for overriding refusal. Instead, it contained intersecting disputes about what capacity requires, whether harmful consequences should influence capacity judgments, how professional duties operate when refusal appears dangerous, and what further conditions must be satisfied before coercive intervention is proportionate.

The first cluster concerned decisional authority. Contemporary accounts distinguish different capacities relevant to refusal and question whether cognition-only assessments adequately capture affective or evaluative agency [10-12]. More revisionary work challenges the centrality of conventional decision-making capacity itself [13]. Diagnosis-specific analysis of anorexia nervosa further identifies internal conflict, compulsion, and irrationality as potentially relevant to authority

without establishing that diagnosis alone defeats it [14]. Across these positions, refusal or disagreement was insufficient by itself to demonstrate incapacity.

A second cluster concerned harmful choice and risk. Some analysis allows the harmfulness of a choice to bear on competence, especially where stakes are grave [15]. Externalist critics answer that an undesirable expected outcome cannot be decisive evidence that the patient's decision-making process is defective [16]. Related work rejects risk-related competence standards that demand more competence as consequences become more serious [17], while a pragmatic counterposition defends limited asymmetry between accepting and refusing recommended care [18]. Capacity rules themselves embody normative judgments [19], and reversibility adds a temporal dimension because some choices preserve later opportunities for correction whereas others do not [20]. Harm therefore intensified protective reasons

without producing consensus that capacity thresholds should rise with risk.

A third cluster shifted attention to assessment conditions. Structured tools may discipline capacity assessment but cannot mechanically settle the moral authority to override [21]. Systems-oriented work emphasizes training, consultation, and institutional processes [22]. In opioid-related refusal, trauma-informed engagement, a strong diminished-capacity account of addiction, and a spectrum model of decisional autonomy represent materially different positions [23-25]. Even where incapacity is accepted, treatment over objection may remain ethically problematic because force, trauma, feasibility, and expected benefit still require justification [26]. Subsequent debate reinforces the distinction between finding a defect in decision making and establishing authority to impose treatment [27].

The fourth cluster concerned rationality, influence, and relational context. Irrational-seeming choices do not automatically extinguish the rights attached to patient choice [28], and misaligned hope or conviction can occupy an ambiguous position between factual error, value commitment, coping, and impaired reasoning [29]. Influence must also be distinguished from coercion: nudging is defended only under conditions that preserve

understanding and meaningful resistance [30]. Relational-autonomy accounts permit interpersonal support without transferring authority away from the patient [31]. Conditional refusal of blood products illustrates why the terms and reasons of refusal matter [32]. Evidence that selective wording can alter do-not-attempt-resuscitation choices further demonstrates the relevance of communication, while remaining insufficient to show that all framing constitutes coercion or that surrogate findings transfer directly to competent adult refusal [33].

Four descriptive findings followed. Refusal is not itself evidence of incapacity. Serious expected harm can strengthen reasons to reassess, inform, deliberate, or intervene without settling the capacity question. Professional obligations commonly include supportive and consultative duties before coercion is considered. Finally, impaired capacity does not automatically make treatment over objection proportionate; the intervention still requires scrutiny of expected benefit, urgency, feasibility, force, trauma, reversibility, and the reasons underlying refusal.

Table 2 compares the principal premises and counterarguments without ranking them by frequency or correctness.

Table 2. Premise structures and counterarguments in arguments about overriding adult treatment refusal

Analytical unit	Premise supporting override	Principal counterargument	Modifying condition
Decisional authority	Refusal results from a material defect in understanding, appreciation, reasoning, or value-responsive agency	Capacity criteria can import paternalistic judgments about acceptable values	Diagnosis, cognition, intoxication, affect, decision complexity
Preventable harm	Respecting refusal risks grave and avoidable harm	Harm does not prove incapacity and may be knowingly accepted	Imminence, reversibility, prognosis, emergency timing
Authenticity/value disruption	Refusal is disconnected from the patient's own evaluative standpoint	Authenticity tests may privilege familiar or clinician-approved values	Addiction, anorexia, unusual belief, religious commitment, misaligned hope
Professional duty	Clinicians must protect patients from preventable harm	A duty to care does not itself confer authority to compel treatment	Urgency, legal authority, institutional responsibility
Least-restrictive response	Supportive alternatives cannot adequately address the threat	"Support" can become manipulative when directed only toward compliance	Time, communication, trauma-informed care, repeated assessment, relational support
Proportionality	Expected benefit justifies burdens of treatment over objection	Restraint, trauma, limited efficacy, or burdensome treatment can defeat justification	Benefit, duration, feasibility, reversibility, safer alternatives

Synthesis of normative arguments

The reviewed literature separates two questions that are often collapsed in practice: whether a refusal retains sufficient decisional authority and whether intervention

over objection would itself be ethically justified. Information quality forms part of the first question because autonomous authorization depends on what the patient has been enabled to understand and evaluate [34].

A refusal reached after materially deficient disclosure, distortion, or misunderstanding therefore warrants further inquiry, but a clinician's view that the decision is medically unwise does not establish that the patient lacks authority.

Across the reviewed arguments, autonomy also resists reduction to an isolated cognitive event. Debates over principlism, distributed responsibility, and relational approaches show that the ethical status of refusal may depend on how the decision was supported, interpreted, and acted upon within clinical relationships and institutions [35-37]. These arguments do not relocate authority from the patient to clinicians, relatives, or consultation services. They instead make the quality of the decision environment relevant to judging whether apparent incapacity reflects a stable deficit, remediable communication failure, coercive circumstances, temporary impairment, or a genuine conflict between clinical interests and the patient's values.

The synthesis therefore identifies decisional authority as the first justificatory condition. Where the patient adequately understands relevant information, appreciates its significance, can reason sufficiently for the decision at hand, and can communicate a choice that is meaningfully attributable to that patient, the ethical presumption against override remains strong. The literature supplies no defensible basis for treating refusal, diagnostic status, irrational-seeming preference, disagreement with clinicians, or the severity of the possible outcome as a substitute for this assessment.

A finding of materially impaired authority changes the ethical landscape but does not complete the argument for treatment over objection. The second condition concerns serious preventable harm. Harm becomes more compelling where deterioration is grave, temporally proximate, and plausibly preventable by the proposed intervention. Yet the expected harm of non-treatment must be distinguished from the expected benefit of treatment. If the intervention is unlikely to achieve the protective aim, compulsory treatment cannot be justified simply by the seriousness of what might otherwise happen.

The third condition is therefore intervention efficacy and proportionality. Ethical justification depends on the probability and importance of benefit together with the burdens created by restraint, forced medication, invasive procedures, repeated coercion, psychological trauma, destruction of therapeutic trust, or prolonged treatment contrary to the patient's expressed values. Capacity

failure cannot by itself erase these burdens. An intervention capable of preventing death may carry a different proportionality profile from a burdensome measure offering marginal benefit, especially where the latter would require sustained physical enforcement.

A fourth condition concerns less restrictive alternatives. Several strands of the literature support efforts to improve understanding, remove communication barriers, address pain or distress, allow intoxication or acute confusion to resolve where clinically feasible, repeat assessment, involve trusted supporters with the patient's authorization, obtain specialist or ethics input, and modify the treatment plan to address the reasons for refusal. These measures are ethically important because restoration or clarification of patient authority can eliminate the need for coercion. The requirement is context sensitive: an immediately life-threatening emergency may shorten the time available for supportive measures, but urgency should be demonstrated from the clinical circumstances rather than presumed from disagreement.

The fifth condition is legitimate professional and institutional authority. A clinician may have a strong duty to prevent avoidable harm while still lacking sufficient ethical, legal, or institutional authority to impose a particular intervention. Consultation, capacity assessment, emergency powers, and organizational responsibility perform different functions. Where circumstances allow, an override decision should therefore be contestable, documented, proportionately authorized, and revisable if the patient's capacity, clinical condition, preferences, or available alternatives change. Treatment limitation literature adds a final temporal consideration. The moral character of professional action cannot always be inferred from the simple contrast between acting and omitting; withholding and withdrawing interventions may require attention to the reasons, consequences, and responsibilities associated with each choice [38]. The same lesson applies to refusal override. A decision to intervene is not justified merely because clinicians describe non-intervention as "allowing harm," just as respecting refusal cannot be defended merely by describing intervention as an active intrusion. The morally relevant features are the patient's authority, the expected trajectory without treatment, the effectiveness and burdens of the proposed response, available alternatives, and the institutional conditions under which coercive authority would be exercised.

These relationships produce an article-specific conditional synthesis. Override becomes progressively more defensible when five requirements converge: a material impairment of decisional authority; a serious and preventable threat; a treatment capable of producing proportionate benefit; inadequacy or infeasibility of less restrictive responses; and legitimate, reviewable professional authority. Each requirement also contains possible defeaters. Reliable decisional authority can

defeat an otherwise strong harm-based argument. Low treatment efficacy or excessive coercive burden can defeat an argument based on incapacity. A feasible supportive alternative can defeat the necessity of immediate compulsion. Institutional or legal uncertainty can require escalation or review even when clinicians believe the substantive case for intervention is strong. The synthesis is summarized in **Table 3**.

Table 3. Contested assumptions that determine whether an argument for overriding refusal remains defensible

Assumption under dispute	What the reviewed arguments permit	What remains contested	Consequence for override justification
Refusal indicates incapacity	Refusal may trigger careful reassessment where impairment is plausible	Whether unusual values, irrationality, diagnosis, or disagreement are evidentially sufficient	Refusal alone cannot carry the justificatory burden
Serious harm establishes authority to intervene	Grave, imminent, avoidable harm strengthens protective duties	Whether harm should affect capacity thresholds or remain a separate consideration	Harm must be evaluated independently from decisional authority
Incapacity is sufficient for treatment over objection	Impaired authority weakens the presumption that refusal controls treatment	Whether coercion is effective, necessary, proportionate, and institutionally authorized	Incapacity opens further analysis; it does not complete it
Professional beneficence requires compulsory treatment	Clinicians retain duties to prevent avoidable harm and support decision making	How far those duties extend when intervention itself causes substantial burdens	Professional duty must be translated through proportionality
Supportive influence is always autonomy preserving	Explanation, reassessment, relational support, and some forms of persuasion can strengthen decision making	When influence becomes manipulative, coercive, or directed solely toward compliance	Less restrictive measures require safeguards for meaningful resistance
Emergency circumstances suspend ordinary protections	Urgency may justify abbreviated assessment or immediate protective action	How urgency is established and when exceptional authority should end	Emergency authority must remain temporally bounded and revisable
Relational involvement can substitute for patient authority	Others may assist understanding, communication, and deliberation	Whether assistance becomes practical control over the decision	Support is compatible with autonomy only while the patient's authority remains identifiable

The conditional architecture is represented in **Figure 2**.

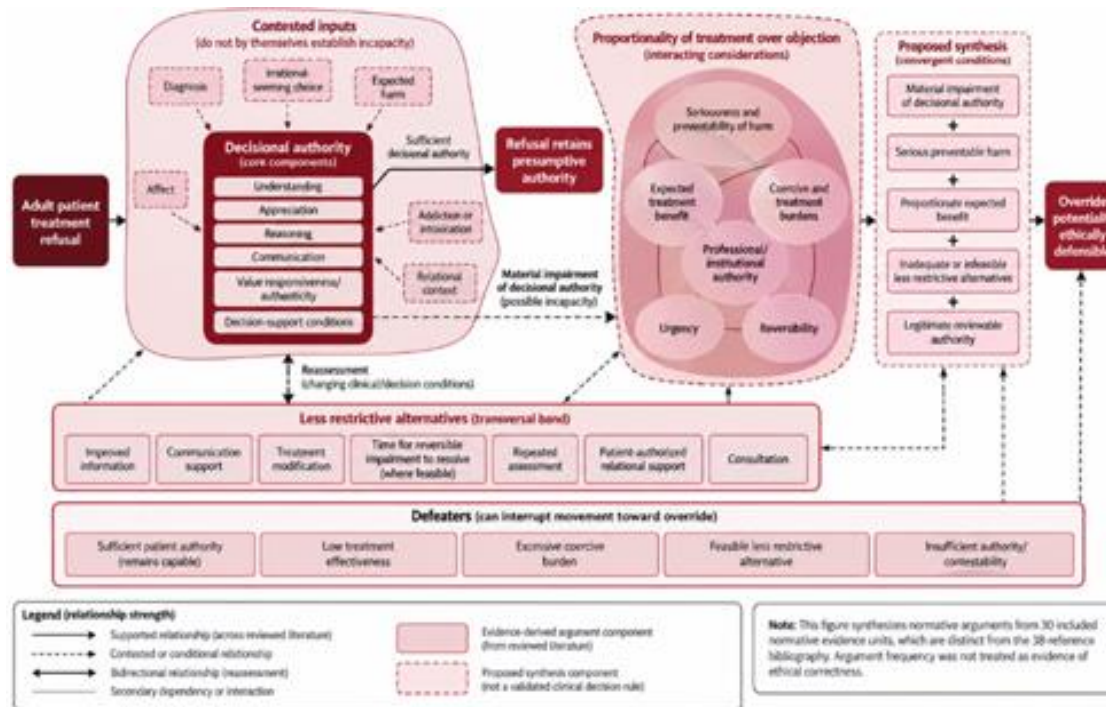


Figure 2. Normative-argument synthesis framework

This review indicates that the ethical question raised by treatment refusal is better represented as two linked judgments. Clinicians first need to determine whether the patient retains sufficient authority over the particular decision. If that authority is materially impaired, they must still determine whether treatment over objection is a proportionate and legitimately authorized response. Keeping these judgments distinct reduces the risk that concern about consequences silently becomes a finding of incapacity.

The distinction has practical importance for capacity assessment. High-risk refusals appropriately prompt careful evaluation, but the expected severity of an outcome should not become a hidden test of whether the patient has reasoned “correctly.” The reviewed arguments repeatedly expose the danger of using diagnosis, unfamiliar values, irrational-seeming preferences, or disagreement with medical recommendations as proxies for incapacity. Greater clinical concern can justify more careful assessment, clarification, and consultation while leaving the substantive capacity criteria stable.

The same separation clarifies professional obligation. Beneficence supports efforts to reduce avoidable harm, yet those efforts can take multiple forms: improving information, treating reversible contributors to impaired cognition, negotiating a less burdensome intervention,

allowing time for reassessment when safe, using authorized relational support, or obtaining independent consultation. Coercive treatment is therefore one possible response within a wider professional repertoire. Its justification becomes stronger where supportive measures cannot restore or clarify authority and delay would expose the patient to grave avoidable harm.

Proportionality also requires attention to the intervention itself. Treatment over objection may involve restraint, sedation, forced transport, invasive procedures, repeated confrontation, or prolonged enforcement. These burdens can be clinically and morally significant even when clinicians correctly identify impaired decision-making capacity. Where expected therapeutic benefit is low, treatment burdens are severe, or enforcement would need to continue for an extended period, incapacity may coexist with a strong reason against coercion.

Conversely, some acute situations can narrow the range of feasible alternatives. A patient with transient impairment who faces imminent catastrophic harm from a highly effective and time-sensitive intervention presents a materially different justification from a patient facing uncertain long-term benefit from burdensome treatment. The ethical significance arises from the configuration of authority, temporality, preventability, effectiveness, burden, and available alternatives; no

single component provides a universal override threshold.

This framework also places institutional safeguards inside the ethical analysis. Capacity consultation can improve decision quality, yet responsibility for treatment over objection cannot be transferred wholesale to the consultant. Clinical teams and organizations remain responsible for ensuring that the proposed intervention is necessary, proportionate, authorized, documented, and open to reconsideration. Where legal standards, emergency powers, organizational policy, or role responsibilities are uncertain, the appropriate response may be escalation and review instead of unilateral coercion.

Relational approaches add an important qualification. Family members, trusted supporters, interpreters, advocates, and other participants may improve communication and help a patient articulate stable values. Their involvement can strengthen the authenticity and reliability of the decision process. The ethical boundary is crossed when support becomes practical substitution for the patient's authority without an independent justification for doing so. The same concern applies to professional influence: persuasion and recommendation are common parts of care, whereas manipulative framing or threats can undermine the conditions required for a meaningful refusal.

The synthesis therefore does not offer a mechanical algorithm. Its contribution is to specify the questions that must remain separate and the conditions that must converge before override can acquire adequate justification. This approach also preserves disagreement in the literature. Some authors favor richer or more demanding accounts of capacity; others resist risk-sensitive or externalist standards. Those disagreements remain significant. The review's joint-condition structure does not resolve them by counting publications but identifies where different philosophical commitments alter the path from concern about a refusal to authority for treatment over objection.

For clinical ethics education, this distinction may help learners avoid two common simplifications: treating autonomy as a command to accept every expressed refusal without examining decisional authority, and treating beneficence as permission to overcome refusals whenever clinicians predict serious harm. A more defensible analysis asks which ethical function each consideration performs and whether the proposed

interference remains necessary and proportionate after that function is specified.

Strengths and limitations

A principal strength of this review is its premise-level approach. PRISMA reporting makes the identification and selection process transparent [7], while argument-based extraction avoids treating heterogeneous normative publications as if they were empirical effect estimates [8]. The synthesis also preserves direct disagreement about capacity, harmful choice, rationality, relational autonomy, professional duties, and coercive intervention instead of converting disagreement into a single prevalence-weighted conclusion.

The review also responds to methodological concerns about the language of "systematic" bioethics review [9]. Its search and selection procedures are systematic in the sense of being documented and reproducible within the executed search environment; normative correctness is not inferred from completeness, frequency, or journal prestige. Argument appraisal was qualitative, and short commentaries were allowed to contribute distinct objections without being treated as equal in depth to full philosophical analyses.

Several limitations remain. The formal identification denominator came from five executed PubMed-domain search batches available through the research interface. Publisher and journal searches were subsequently used for bibliographic verification and citation chaining, but they were not counted as independent database records. The review therefore provides a reproducible account of the searches actually executed rather than claiming exhaustive capture of every philosophical or legal database.

The literature was also heterogeneous in form. Full normative articles, open peer commentaries, empirically informed ethics papers, and context-specific analyses differed in argumentative depth. Several highly relevant debates concerned opioid overdose, anorexia nervosa, psychiatric detention, dementia, blood refusal, or end-of-life care, and their conclusions cannot automatically be generalized across all adult clinical settings. Legal authority also varies by jurisdiction, so the synthesis should not be read as a statement of universal law.

Finally, the proposed joint-condition framework is an interpretive synthesis, not a validated clinical scoring instrument. No numerical threshold establishes when impairment, harm, benefit, or coercive burden becomes sufficient. Its value lies in preserving distinctions that the

literature shows to be ethically consequential and in making explicit where further empirical, legal, and normative work is required.

Conclusion

Overriding an adult patient's treatment refusal is most ethically defensible under a demanding combination of conditions rather than through any single finding. The patient's decisional authority must be materially compromised; the threatened harm must be serious and plausibly preventable; the proposed treatment must offer proportionate benefit; less restrictive responses must be inadequate or infeasible; and the exercise of coercive authority must itself be legitimate, reviewable, and sensitive to the burdens it creates.

Serious harm can justify closer assessment and stronger protective efforts without converting an unwise refusal into incapacity. Likewise, incapacity can weaken the authority of refusal without making every beneficial intervention proportionate. The ethically defensible case for override is therefore strongest when impaired authority, preventable harm, effective treatment, necessity, proportionality, and accountable professional authority converge—and weakest when any of those conditions remains substantially unresolved.

Acknowledgments: None

Conflict of Interest: None

Financial Support: None

Ethics Statement: None

References

1. Angelova Y, Cheung S, Thearle MS, Robbins-Welty GA, Mirza OF. Respecting the right to refuse: Is decision-making capacity disproportionately challenged in patients declining medical care in order to treat? *J Med Ethics*. 2025. doi:10.1136/jme-2025-111141
2. Marshall KD, Derse AR, Weiner SG, Joseph JW. Revive and refuse: Capacity, autonomy, and refusal of care after opioid overdose. *Am J Bioeth*. 2024;24(5):11-24. doi:10.1080/15265161.2023.2209534
3. Aylsworth T, Greenblum J. Decision-making capacity and authenticity. *J Bioeth Inq*. 2025;22(1):85-93. doi:10.1007/s11673-024-10372-w
4. Quan A. The ethics of overriding patient refusals during 5150s and other involuntary psychiatric holds. *Bioethics*. 2024;38(8):667-73. doi:10.1111/bioe.13331
5. Gudex L, Hristova E, Hathaway J, Firn J. When prima facie duties collide: Ethical responses to refusal of basic nursing care. *Nurs Ethics*. 2026;9697330261463755. doi:10.1177/09697330261463755
6. Wright MS. Hospitals are not prisons: Decision-making capacity, autonomy, and the legal right to refuse medical care, including observation. *Am J Bioeth*. 2024;24(5):37-9. doi:10.1080/15265161.2024.2327293
7. Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *BMJ*. 2021;372. doi:10.1136/bmj.n71
8. Rodrigues P, Crokaert J, Gastmans C. Palliative sedation for existential suffering: A systematic review of argument-based ethics literature. *J Pain Symptom Manage*. 2018;55(6):1577-90. doi:10.1016/j.jpainsymman.2018.01.013
9. Birchley G, Ives J. Fallacious, misleading and unhelpful: The case for removing 'systematic review' from bioethics nomenclature. *Bioethics*. 2022;36(6):635-47. doi:10.1111/bioe.13024
10. Navin MC, Brummett AL, Wasserman JA. Three kinds of decision-making capacity for refusing medical interventions. *Am J Bioeth*. 2022;22(11):73-83. doi:10.1080/15265161.2021.1941423
11. Hawkins J. Affect, values and problems assessing decision-making capacity. *Am J Bioeth*. 2024;24(8):71-82. doi:10.1080/15265161.2023.2224273
12. Harcarik L, Kim SYH, Millum J. The ability to value: An additional criterion for decision-making capacity. *Bioethics*. 2025;39(3):288-95. doi:10.1111/bioe.13387
13. Fogal D, Schwan B. Ditching decision-making capacity. *J Med Ethics*. 2025;51(12):832-40. doi:10.1136/jme-2023-109047
14. Wong KHC. Three sources of incapacity in anorexia nervosa. *Bioethics*. 2026;40(4):380-6. doi:10.1111/bioe.70053

15. Pickering N, Newton-Howes G, Young G. Harmful choices, the case of C, and decision-making competence. *Am J Bioeth.* 2022;22(10):38-50. doi:10.1080/15265161.2021.1941422
16. Earp BD, Demaree-Cotton J, Savulescu J. Against externalism in capacity assessment—why apparently harmful treatment refusals should not be decisive for finding patients incompetent. *Am J Bioeth.* 2022;22(10):65-70. doi:10.1080/15265161.2022.2112462
17. Pickering NJ, Newton-Howes G, Walker S. Risk-related standards of competence are a nonsense. *J Med Ethics.* 2022;48(11):893-8. doi:10.1136/medethics-2021-108107
18. Douglas T. Pragmatic argument for an acceptance-refusal asymmetry in competence requirements. *J Med Ethics.* 2022;48(11):799-800. doi:10.1136/jme-2022-108662
19. Hass B. The values and rules of capacity assessments. *J Med Ethics.* 2022;48(11):816-20. doi:10.1136/medethics-2021-107923
20. Hass B. Reasoning and reversibility in capacity law. *J Med Ethics.* 2023;49(6):439-43. doi:10.1136/jme-2022-108462
21. Radenković M. Importance of decisional capacity tools in obtaining informed consent in clinical settings. *Bioethics.* 2023;37(2):146-53. doi:10.1111/bioe.13121
22. Geppert C, Tarzian A, Sussman J, Hester H. Enhancing decision-making capacity assessments beyond outlier cases: A multi-faceted health care systems approach. *Am J Bioeth.* 2024;24(8):90-3. doi:10.1080/15265161.2024.2361914
23. Cattell C, Hyshka E, Leier B, Mack C. Capacity, rationality, and the promotion of autonomy: A trauma-informed approach to refusals of care after opioid poisoning. *Am J Bioeth.* 2024;24(5):48-51. doi:10.1080/15265161.2024.2327285
24. Engel GR, Boyd JW. Everyone with an addiction has diminished decision-making capacity. *Am J Bioeth.* 2024;24(5):34-7. doi:10.1080/15265161.2024.2327289
25. Smith JN, Smolenski J, Lang BH, Blumenthal-Barby J. From opioid overdose to LVAD refusals: Navigating the spectrum of decisional autonomy. *Am J Bioeth.* 2024;24(5):8-10. doi:10.1080/15265161.2024.2329496
26. Randall P, Shelton W. Barriers to overriding refusal for patients who lack capacity. *Am J Bioeth.* 2024;24(8):109-11. doi:10.1080/15265161.2024.2361901
27. Navin MC, Brummett AL, Wasserman JA. Capacities to refuse treatment: A reply. *Am J Bioeth.* 2024;24(3). doi:10.1080/15265161.2023.2201200
28. Appel JM. Irrational people have rights too: Moving beyond rationality in decisional capacity assessment. *J Bioeth Inq.* 2026. doi:10.1007/s11673-025-10527-3
29. Clarke S, Oakley J, Pugh J, Wilkinson D. Misaligned hope and conviction in health care. *Bioethics.* 2025;39(3):232-9. doi:10.1111/bioe.13370
30. Miyata A. When should doctors nudge? Nudging and preference-sensitive care. *J Med Ethics.* 2025. doi:10.1136/jme-2024-110268
31. Foo KF, Lin YP, Lin CP, Chen YC. Fostering relational autonomy in end-of-life care: A procedural approach and three-dimensional decision-making model. *J Med Ethics.* 2026;52(6):400-7. doi:10.1136/jme-2023-109818
32. Tarzian A. Autonomy, truth-telling, and beneficence: A Jehovah's Witness case of conditional refusal of blood products. *Am J Bioeth.* 2026;26(1):127-8. doi:10.1080/15265161.2026.2594940
33. Inarimori K, Maeda Y. Influence of selective phrasing on consent to DNAR. *BMC Med Ethics.* 2026. doi:10.1186/s12910-026-01548-7
34. Rees M. Patient autonomy and withholding information. *Bioethics.* 2023;37(3):256-64. doi:10.1111/bioe.13130
35. Harris J. Autonomy deadlock and bioethical principlism. *Am J Bioeth.* 2026;26(3):52-6. doi:10.1080/15265161.2026.2623871
36. Sahota PKC. Capacity consultations and moral responsibility for the safe disposition. *Am J Bioeth.* 2026;26(6):83-5. doi:10.1080/15265161.2026.2657890
37. Weiss AP. Beyond the dementia dyad: Rethinking capacity in a distributed mind. *Am J Bioeth.* 2026;26(4):67-9. doi:10.1080/15265161.2026.2637096
38. Cameron J, Savulescu J, Wilkinson D. Is withdrawing treatment really more problematic than withholding treatment? *J Med Ethics.* 2021;47(11):722-6. doi:10.1136/medethics-2020-106330