

# **Medical Education Systems, Inc.**



## **Perspectives: Determining when Medical Treatment is Futile**



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# Perspectives: Determining When Medical Treatment is Futile

## Learning Objectives

Upon successful completion of this course, you will be able to:

- Define what is meant by medical “futility”
- Identify the individuals whose input is important in making “futility” decisions
- Identify the various circumstances that can exist in which “futility” decision-making is required
- Discuss the role of “ethics” in futility discussions

## Introduction

**ETHICS CASE :** Sixty-eight-year-old man is hospitalized with acute stroke after collapsing on the golf course. Upon admission, patient was treated with TPA. His stroke subsequently became hemorrhagic, requiring emergent craniotomy. The patient never regained consciousness.

After two weeks, his wife consented for tracheostomy and gastrostomy tube insertion. One month after admission, he remains unresponsive. He has non-purposeful movements of his left side. He does not follow commands. His pupils are equal but unresponsive to light. The ICU nurse has requested an ethics consult because she believes continued life-sustaining treatment is futile. His wife still believes he will recover and is requesting that “everything be done.” Who should decide when treatment is futile?

## CASE DISCUSSION:

**Nurse:** “I took care of this patient when he was first admitted but did not see him again until these past few days. If anything, he looks worse now. I think it is wrong to keep him hooked up to the ventilator with no real hope that he will ever wake up or go home.”

**Neurologist:** “This patient has no realistic chance of regaining consciousness, but he does not meet the criteria for brain death. I believe removing life-sustaining treatment and letting the patient die would be the best course of action at this point, but part of my concern in doing this against his wife’s wishes is the fact that I administered the TPA, which may have lead to the complication of converting this to a hemorrhagic stroke, and I am concerned the wife might take legal action if I cross her.”

**Patient’s Wife:** “As long as my husband is still alive, I’m just happy to be with him. At least we are still together. I am still hoping that he will be able to get off the breathing machine, get better, and go home again. I believe in whatever God wants for him. If God were ready for him, he would take him. I know he wouldn’t want to live like this permanently, but I’m not ready to say it’s enough because there is just never enough time. Maybe death is worse than this.”

**Patient’s Daughter** (the only other involved family member): “Three months ago, I had a discussion with my dad regarding his wishes and values. He told me at that time that quality of life for him was being with his grandchildren, going on long walks with my mom, golfing with his buddies, and

tinkering around in the garage. If he could no longer do those things, then life for him would not be worth living. I know he would not want to be kept alive on machines, but I am just trying to support my mom because I think it has to be her decision.”

## ETHICAL CASE ANALYSIS :

When conducting an ethics consultation, there are various formats that can be followed. The most universally used approach is based on the Jonsen’s “fourbox approach”: medical indications, patient preference, quality of life, and contextual features. Following is my analysis of this case using this model:

**1) Medical Indications:** This patient is permanently unconscious with no realistic chance of regaining consciousness. He will likely be permanently dependant on a ventilator as multiple attempts to wean him have been unsuccessful, and his weaning parameters have shown no sign of improvement. Obviously, he will also be permanently feeding-tube dependant. With continued treatment, he could survive for months to years in this state, likely requiring permanent placement in a long-term care facility. If he is extubated, he will most likely die within hours to days.

**2) Patient Preference:** The patient does not have an advance directive. The only information we have regarding his wishes is his conversation he had with his daughter three months prior to admission. At that time, he clearly defined what quality of life is to him: being with his grandchildren, golfing, walking, and working in his garage. Beyond those statements, we have no way of knowing what the patient’s preferences would be regarding his current treatment decisions.

Would he want to be maintained on life-sustaining treatment with no reasonable chance of recovery? When we are trying to ascertain what the patient’s preferences are regarding treatment once they have lost decision-making capacity, we rely on a variety of sources. The source that carries the most weight is a written advance directive. In cases where the patient has no advance directive such as this one, the second source is verbal statements made to someone on the treating team, usually a physician or nurse. The final source is prior conversations with friends or family in which a patient may have discussed his or her preferences. In this case, we have no specific directive from the patient. We therefore must base our decision-making on “Quality of Life” factors in the next section.

**3) Quality of Life:** In each case, we must prognosticate the best possible outcome we will be able to achieve, the likelihood of achieving it, and the burden of treatment that must be endured in order to achieve our goal. We must then determine whether that outcome and the burden of treatment are acceptable to the patient. If we have statements from the patient regarding his or her preferences, our decisions must be guided by those stated wishes. If we have no statements regarding the patient’s preferences, then we must try to infer their preferences based on what we know of the patient’s values. This is when the “substituted judgment” of a surrogate decision maker becomes vital. It is always best to ask, “If your loved one could speak to us right now, what do you think he or she would tell us they want?” In this case, both the daughter and wife confirmed that the patient “would not want to live like this.”

We must conclude that the most likely outcome in this case — maintaining the patient in a permanently unconsciousness state — would not be consistent with the patient’s stated wishes and lifelong values.

**4) Contextual Features:** This includes other interested parties who might influence decision-making (other family members or staff who disagree), legal implications, financial/economic factors, religious or cultural factors, resource allocation, public health issues, etc. In this case, the patient was insured, and his wife was financially secure. She did hold some religious beliefs that likely impacted her decision-making. It is unclear whether the patient shares his wife's particular religious beliefs. Another feature in this case might be the physician's concern of medical error and risk of legal liability with a bad outcome. These concerns certainly impact physicians' clinical decision-making, but, ultimately, physicians must pursue the decision they think is best for the patient and disclose any medical error or adverse outcomes from treatments rendered.

#### **SUMMARY & RECOMMENDATIONS:**

This case illustrates the issue of determining medical futility. Medical ethicists have not been able to arrive at a universally accepted definition of medical futility. Many have proposed a quantitative definition, such as treatment having a less than 5 percent or less

## **Medical futility in pediatrics: Is it time for a public policy?**

Journal of Public Health Policy, by Clark, Peter A

FOR the past decade, there has been a debate raging within the medical, ethical, and legal communities focusing on the issue of medical futility. Despite the emergence of medical futility as a dominant topic of discussion, especially as it applies to end-of-life care, the concept is not new (1). Physicians since the time of Hippocrates, and even before, recognized some medical conditions as futile and unworthy of further treatment for the patient (2). What has fueled the fires of this multi-faceted debate is the patient rights movement and the perception that the right of self-determination extends not only to the refusal of medical treatments but to demands for overtreatment (3). The patient rights movement began as a reaction to the paternalism of physicians who unilaterally overtreated patients and prolonged their lives against their wishes or the wishes of surrogates and family members. The perception of this physician-driven overtreatment resulted in a series of legal cases ranging from the Quinlan case in 1975 to the Cruzan case in 1990, which gave patients or their appropriate surrogates the legal right to refuse medical treatment, even if this resulted in the patient's death. Physicians argued that these treatments were appropriate; however, the courts ruled in favor of the patient's right to determine his or her own medical treatment. In the 1990s, patients/surrogates began to demand overtreatments that physicians believed were not in the best interest of the patient because they were medically futile and represented an irresponsible stewardship of health care resources. In legal cases ranging from the Wanglie case in 1991 to the Baby K case in 1994, the courts have ruled in favor of the right of patients/surrogates to request certain medical treatments (4). What has been problematic for the judges in these cases has been the lack of professional or institutional policies on medical futility against which they could judge compliance or noncompliance (5).

These complex cases have set the stage for the present debate on medical futility, which pits patient autonomy against physician beneficence and the allocation of social resources.

The medical specialties of Pediatrics and Neonatology further complicate the issue of medical futility because despite the dramatic technological advances in these areas, diagnostic and prognostic certainty for many medical conditions remains illusive. As a result, surrogates have to decide whether children with various diseases, congenital anomalies, and genetic defects should be treated aggressively if at all. This uncertainty has led to many handicapped children with serious medical conditions being treated aggressively. As a result, conflicts between physicians and families have arisen about whether certain medical treatments are futile and thus not in the best interest of the child (6). These conflicts have had far-reaching ramifications for all concerned, because what is at stake is the life of an innocent child. Death is difficult enough to accept when it involves an adult, but when the death of a child is at issue, the perspective is altered dramatically. The death of a child, especially when it results from withholding or withdrawing medical treatment, can be viewed as unjust, premature, and even cruel. The mere mention of distributive justice and scarce medical resources only compounds the complexity of medical futility decisions, because many Americans view this as placing a price tag on human life. The mere thought of placing a price tag on any human life, particularly the life of a child, is revolting to many Americans. As a result, the judgments of parents become clouded by emotions and irrationality, and some children with futile conditions are aggressively treated instead of being allowed to die with dignity and respect.

Judgments about the benefit or burden of treatments require honest assessments of outcomes in particular patients, not sentimental or unrealistic comparisons (7). Unfortunately, at the present time, parents are unilaterally dictating what is in the best interest of the child in the name of patient autonomy. Ethically, parents and surrogates argue that if they have the right to withhold or withdraw certain medical treatments this also gives them the right to request certain medical treatments, because they know what is in their child's best interest. Physicians argue that many of these interventions are burdensome for the child and medically inappropriate because they fail to achieve the proper physiological effect and result in a misallocation of medical resources. At a time when health care is being rationed through managed care, social justice demands that medical resources, time, and professional energy be devoted to better outcomes (8). Allowing these treatments compromises the physician's professional integrity, but many physicians feel compelled to comply with the surrogate's wishes, because they believe that society has mandated the provision of such interventions until surrogates agree to their being withheld (9). The ever-present fear of litigation has not only fueled this debate but also has placed the very foundation of the physician-patient relationship in jeopardy. This notion of patient autonomy holds physicians and hospitals hostage by insisting that medicine owes patients miraculous feats (10). This position of absolute autonomy ignores the fact that a well-established "best interest" standard assumes both a connectedness of the patient to family and physician and a communication process that allows surrogates to decide based on objective, community-based best interest standards (11). To address these concerns a balance will have to be found which avoids both the traditional physician-driven overtreatment and recent surrogate-driven overtreatment and seeks to balance patient/surrogate rights with physician/societal rights (12). From a legal and an ethical perspective one way to foster this balance would be a process-based approach to futility determinations on a case-by-case basis. This author has advocated such a process-based approach for acute care facilities (13). However, because Pediatrics and Neonatology are so specialized and deal with minors, a specific process-based public policy needs to be advanced to address this challenging area.

The goal of this process-based approach would be a medical futility policy which protects the patient's right to self-determination; the physician's right of professional integrity; society's concern for the just allocation of medical resources; and is securely rooted in the ethical tradition of promoting and defending human dignity.

The purpose of this article is threefold: first, to examine the issue of medical futility; second, to give an ethical analysis of patient autonomy, physician beneficence, and the just allocation of medical resources and how they impact ethically on determining if a treatment is medically futile; third, to propose a medical futility policy for Pediatrics and Neonatology.

## **MEDICAL FUTILITY**

Futility means "inadequacy to produce a result or bring about a required end; ineffectiveness" (14). Medically, the concept of "futility," according to the American Medical Association, "cannot be meaningfully defined" (15). Essentially, futility is a subjective judgment, but one that is realistically indispensable (16). There is consensus within the medical community that some treatments are medically futile; however, consensus ends when attempting to formulate a fully objective and concrete definition. As a result, futility has been confused with interventions that are harmful, impossible, and ineffective. Distinguishing futility from these other concepts has led to some clarity. In general, a medically futile treatment is "an action, intervention, or procedure that might be physiologically effective in a given case, but cannot benefit the patient, no matter how often it is repeated. A futile treatment is not necessarily ineffective, but it is worthless, either because the medical action itself is futile (no matter what the patient's condition) or the condition of the patient makes it futile" (17). However, until there is a more clear understanding of what medical futility means at the bedside, there will not be widespread agreement of definitions and implications of futility in general (18).

Ethicists Baruch Brody and Amir Halevy have distinguished four categories of medical futility that set the parameters for this debate. First, physiological futility, also known as quantitative futility, applies to treatments that fail to achieve their intended physiological effect. These determinations are not based on vague clinical impressions but on substantial information regarding the outcomes of specific interventions for different categories of patients. Second, imminent-demise futility exists when despite that intervention the patient will die in the very near future (this is sometimes expressed as the patient will not survive to discharge, although that is not really equivalent to dying in the very near future). Third, lethal-condition futility exists when the patient has an underlying lethal condition which the intervention does not affect and which will result in death in the not-too-distant future (weeks, perhaps months, but not years) even if the intervention is employed. Fourth, qualitative futility is an intervention that fails to lead to an acceptable quality of life for the patient (19). When a treatment is judged to be qualitatively futile the claim being made is that, although the treatment may be successful in achieving an effect, the effect is not worth achieving from the patient's perspective (20). Medically, a consensus concerning the clinical features of medical futility remains elusive. "Whatever futility means, it seems obvious that this is not a discrete clinical concept with a sharp demarcation between futile and non-futile treatment" (21). However, what these four categories emphasize is that decisions on medical futility must be made on a case-by-case basis and must include both a substantive component and a role for patient/surrogate input. Determining whether a medical treatment is futile basically comes down to whether it passes the test of beneficence, that is, will this treatment be in the patient's "best interest."

The test of beneficence is complex because determining whether a medical treatment is beneficial or burdensome, proportionate or disproportionate, appropriate or inappropriate, involves value judgments for both the patient/surrogate and the physician.

To understand futility one must recognize that it is a clinical fact with medical moral implications (22). For 3,500 years physicians have realized that some treatments are medically futile and patients were instructed not to expect medical treatments under these circumstances. The Hippocratic corpus prescribed three roles for the physician: alleviating suffering in the sick, reducing the violence of their diseases, and refusing to treat those who were "overmastered" by their diseases, realizing that in such cases medicine is powerless. Futility was viewed as an empirical appraisal of probable clinical outcome, benefit, and burden (23). Today, various medical and bioethical organizations have risen to the challenge of affirming the limits of medicine by agreeing with this long-standing historical view that there is no moral obligation to provide futile treatments (24). However, despite this apparent consensus, the determination of when such medical treatments are clearly futile continues to plague both medical and ethical professionals.

To address this concern, physician-bioethicist Edmund Pellegrino has established a combination of subjective and objective criteria which will allow decision-makers in consultation with physicians to make medical decisions about when certain treatments are no longer beneficial. His approach, which is historically based, strikes a balance between three criteria: effectiveness, benefits, and burdens. For Pellegrino, "this balance is not a mathematical but a moral calculation, based on clinical assessment, which gives a weight to each of these three dimensions in relationship to the other, and ultimately, to the patient's good," (25). His understanding of these three criteria is quite clear. Effectiveness is an estimate of the capacity of the medical treatment to alter the natural history of the disease or symptoms in a positive way. This is an objective determination which is dependent upon outcome studies and within the domain of the physician's expertise. It centers on the medical good and on measurable clinical data about prognoses and therapeutics. Benefit refers to that which is valuable to the patient as perceived by the patient or his or her surrogate. This is a subjective determination and not within the physician's domain but in that of the patient or surrogate decision-maker. Benefit centers on the patient's assessment of his/her own good, that is, the values and goals in undergoing treatment. Burden refers to the physical, emotional, fiscal, or social costs imposed on the patient by the medical treatment. Burdens are both subjective and objective and within the domain of both the physician, when factual, and patient/surrogate, when subjective and personal. Those burdens imposed on the medical team or society would, in certain rare circumstances, be considered as well as burdens on the patient. To determine if a medical treatment is beneficial or futile will depend on an assessment of the three criteria. If the assessment is favorable and in the patient's best interest, all things being equal, then the treatment is morally justifiable. When the assessment is unfavorable and not good for the patient, then the treatment in question is not morally justifiable (26).

The determination of medical treatments as beneficial or futile cannot be made within a vacuum. These are decisions which ought to be made by integrating the expertise of various authorities and combining both objective and subjective components, but always with the primary focus being on what is in the best interest of the patient (27). Ultimately, these are value judgments in which prudence is used to determine if the effectiveness and benefits of treatment outweigh the burdens.

In many ways Pellegrino's criteria are a further specification of the ordinary/extraordinary-means distinction that was rooted in the Catholic moral tradition. The tradition maintains that if a medical intervention is judged to be ordinary, it must be considered morally mandatory. If extraordinary, it is considered morally optional. It is said to be ordinary if it offers a reasonable hope of benefit for the patient and could be used without excessive inconvenience which includes risk, pain and expense. If it offers no reasonable hope or benefit or is excessively burdensome, it is extraordinary (28). In the determination of whether a medical treatment is ordinary or extraordinary, one must examine the

circumstances of a particular situation, which includes cost factors and allocation of resources, because these circumstances dictate the balance to be considered between life and these other values (29). Examining the effectiveness, the benefits, and the burdens of any treatment gives physicians the ethical justification to refuse medical treatments if they are either gravely burdensome or medically futile for the patient.

## **ETHICAL ANALYSIS**

Patients have the right of self-determination to control their own medical treatment, but this does not give patients the absolute right to demand any medical treatment. Physicians have the duty to practice medicine responsibly, that is, they are called to follow professional norms, standards, and values as guides to their judgments on the appropriateness of medical interventions for their patients. However, this does not mean that they can determine medical treatments for patients unilaterally. Ethically, the issue of medical futility focuses on the conflict between the values of the patient/surrogate and the values of the physician (30). Medical judgments are never value free. In coming to the assessment of whether a treatment is medically futile, physicians must consider carefully the values and goals of the patient as well as community and institutional standards. The values of the patient, physician, and society as a whole, are all part of this decision-making process. The question is: how does the physician balance all these values so that the best interest of the patient is always the central focus? This author will argue that the ethical principles of autonomy, beneficence, and justice will provide a moral framework for making medical and ethical decisions about whether a particular treatment is medically futile.

Autonomy refers to the right of a person to exercise self-determination in making personal and informed choices. In the case of medical futility, autonomy refers to the right of a patient/surrogate to choose among certain medically justifiable options. The patient has the right to choose and refuse medical treatments but the physician also has the right to make choices based on his or her duty to practice medicine responsibly. In this situation, both patient and physician have the right of autonomy in making these medical decisions. Legally and ethically, patients have been given the right to refuse medical treatments; however, this right does not imply that they also have the right of access to any medical treatment. Patients have the right to make medical decisions they believe are in their best interest, but at times, due to various factors, these decisions may be destructive and irrational choices. It is at this point that patient autonomy conflicts with physician beneficence. A physician cannot be forced to make a decision concerning a medical treatment which he or she believes not to be in the best interest of the patient or society as a whole. To do so would violate the professional norms of the physician, in that the physician would be asked to practice irrational medicine. To initiate or continue medical interventions even though the patient is no longer able to appreciate any benefit from these interventions is to confuse means with ends, effects with benefits, and available technologies with obligatory medical therapies (31). This is not only an irrational act; it is morally irresponsible.

Autonomy focuses on the dignity and respect of every person. This does not mean that every person has absolute autonomy. Respect for persons embraces self-governing decision-making, but always within the constraints of ethical and moral determinants (32). Therefore, to allow patients/surrogates to think that certain medical treatments are acceptable when they are futile is to deceive them. "By offering a treatment to a patient, a physician conveys that the treatment represents a medically acceptable alternative. But if the treatment actually is almost certain to fail and the patient is misled into believing in the treatment's efficacy, then the physician has violated the patient's trust" (33). This

violates the principle of autonomy, in that "it creates a sphere of decision making where (rationally) none exists, and, thus seems intrinsically deceptive" (34). If the conflict between patient and physician prevents a consensus decision, then the only option for the patient is to terminate the patient-physician relationship and seek another physician. For the physician, there are three options: the physician can either arrange for transfer of the patient; seek a declaratory judgment in court; or act without the patient's approval. To act without patient approval is rare and litigation may ensue, but if the physician has acted within generally accepted medical standards and/ or in conformance with the expressed wishes of the patient, the physician should prevail (35).

Beneficence involves the obligation to prevent and remove harms and to promote the good of the person by minimizing the burdens incurred and maximizing the benefits to the patient and others. Beneficence includes nonmaleficence, which prohibits the infliction of harm, injury, or death upon others.

In determining whether a particular treatment is beneficial to the patient it is important to distinguish between quantitative futility and qualitative futility. Quantitative futility is an objective assessment of a particular medical treatment that should be made by the physician. Ethicists Schneiderman and Jecker have proposed that for a treatment to be medically futile it has to have been useless in the last 100 cases of a physician's personal experience or in published reports. A treatment that merely preserves permanent unconsciousness or cannot end dependence on critical care should also be considered futile.

Furthermore, in judging futility, physicians must distinguish between an effect, which is limited to a part of the patient's body, and a benefit, which appreciably improves the person as a whole (36). Physicians have an ethical responsibility to provide those treatments to their patients which they believe will benefit them as persons and not harm them or be too burdensome for them. The Hippocratic Oath identifies the task of physicians as twofold: first, "to use treatment to help the sick according to my ability and judgment;" second, "never [to use a treatment] with a view to injury and wrongdoing" (37). The oath provides a basis therefore, for claiming that physicians should be permitted not only to refrain from using futile interventions but also to be encouraged or required to refrain from using futile treatments because these interventions fall outside the scope of helping the sick (38). To do otherwise would directly harm the patient. However, in determining whether a particular treatment is beneficial or non-beneficial, patients/surrogates must also be permitted to determine the impact of that treatment on their quality of life.

In general, patients/surrogates will make decisions that are rational and in the patient's best interest, but situations arise when they may not be thinking rationally. This is especially true in situations dealing with neonates and children. Parents are often under severe emotional distress and can be emotionally ill-equipped to make these decisions.

"Commitment to beneficence demands at least that physicians try to understand patients' [surrogates'] intent and motivation and to influence them to make a rational decision. In some cases, physicians may choose not to act on patient [surrogate] decisions that appear to be unreasonably destructive (39). For a patient/surrogate, discerning if a medical treatment is beneficial or nonbeneficial is a subjective determination that centers on this individual's assessment of the good of the patient. This is a value judgment about what the decision-maker believes is in the patient's best interest. Physicians need to take the time to communicate with their patients or patients' surrogates in order to get a better understanding of the physical, emotional, spiritual and financial values that govern their lives. The values and goals of the patient should help to inform a physician's decisions, but they must be considered alongside the professional standards that reflect medical values and guide judgments about

the appropriateness of a medical treatment. Physicians have the expertise to determine whether a medical treatment is quantitatively futile. They should never comply with a decision-maker's request to offer a treatment that is clearly physiologically futile, burdensome, and is certain only to prolong a seemingly meaningless life. Patients/surrogates are in the best position to determine whether a medical treatment is qualitatively futile, that is, beneficial or burdensome according to his or her values. Ideally, the physician and patient/surrogate together should come to a decision about the appropriateness of a particular medical treatment and whether such treatment will maximize the benefits and minimize the burdens for the patient. Shared decision making that is rooted in the concept of reasonableness and allows for flexibility, openness, and honesty is the only model that will pass the test of beneficence. Strong medical paternalism and absolute patient autonomy not only fail the test of beneficence, but also may at times fail the test of non-maleficence.

Justice recognizes that all people should be treated fairly and be given what they are due. The issue of medical futility focuses specifically on distributive justice, that is, the fair, equitable, and appropriate distribution of medical resources in society. In determining if a particular medical treatment is futile, one cannot remove this decision from the realm of social justice. At a time when health care reform is a priority in this country, medical treatments that are judged to be futile and inappropriate are inconsistent with the standards of society and violate the principle of distributive justice. Access to basic health care benefits for all Americans will never be realized if unreasonable medical care continues to be offered. Despite the important role distributive justice plays in the futility debate, it is rarely mentioned as a major factor. The mention of cost factors and scarce resources in discerning medical treatments brings the criticism that one is "putting a price tag on human life," even though, by not having some kind of universal health care coverage, the United States puts a price tag on human life in a massive way every day. This criticism becomes even more pronounced when the human life is that of a child. To many Americans this is totally unacceptable. Human life is too important to place a price tag on; but is this realistic? Medical resources are limited and must be conserved. Proper stewardship of these medical resources entails not exhausting them on medical treatments that are futile and inappropriate. Instead, these resources must be rationally allocated. To waste such resources is ethically irresponsible and morally objectionable.

Citing cost factors and the allocation of scarce medical resources is a compelling argument because it seems to be a value-neutral approach to resolving medical futility conflicts. Unfortunately, this argument is not without its problems. The first problem centers on the current nature of health care in the United States. Unlike other countries, our system does not have a defined budget and is not centrally regulated. Regardless of whether a single-payer healthcare system is a good idea overall, it has unavoidable implications for arguments about medically futile treatments.

Whereas British or Canadian clinicians may be able to argue truthfully that money not spent on futile treatments could be put toward a better medical use such as improved disease prevention or health maintenance, United States physicians can make this claim but it could never be verified. Money saved in one area of healthcare is not necessarily spent in another area of healthcare, or even on worthwhile programs such as education or welfare. In fact, several studies argue that termination of treatment at the point that patients reach any plausible definition of futility would save only a modest amount of money (40). Those who are cynical by nature would say that the savings most likely end up as a positive balance on the corporate earnings sheet of the hospital. This may be true but does it mean we should use scarce medical resources for nonbeneficial treatments? If the current system does not allow for the appropriate use of funding, then fix the system; do not avoid the problem. The problem of cost and allocation of medical resources is not going to disappear. It needs to be addressed now (41).

Critics also will argue that incorporating distributive justice into the medical futility debate is just a devious disguise for medical rationing. This only confuses the issue. Futility judgments and allocation decisions are very different from rationing. Futility refers to specific treatments and outcome relationships with a specific patient. Rationing refers to withholding of efficacious treatments in the general population on a cost basis because of competing needs (42). "Therefore, in making judgments about futility, the patient's benefit is of paramount concern and all that matters is medicine's ability to offer some minimal promise to achieve that benefit. All other factors are extraneous. With respect to rationing, by contrast, society must decide how to deal with conditions of scarcity in which certain treatments cannot be made available to all who would benefit" (43). As a matter of justice, patients/surrogates cannot be given the absolute right to demand any medical treatment. To do so would create a system that "would irrationally allocate health care to socially powerful people with strong preferences for immediate treatment to the disadvantage of those with less power and less immediate needs" (44). If patients/surrogates are given the absolute right to demand inappropriate and nonbeneficial medical treatments, then justice would be accomplished at the expense of the poor, the powerless, and the marginalized. Failure to consider the allocation of scarce resources in this debate would be a grave injustice.

The medical futility debate comes down to a conflict between patient autonomy versus physician beneficence and distributive justice. In seeking a balance between the values and goals of medicine and the values and goals of the patient, individual autonomy cannot be so inflated in importance as to destroy the principle of beneficence and overlook the equitable distribution of medical resources in society. To find this balance, physicians must reach a consensus on what constitutes a reasonable medical treatment, and patients/surrogates must restrict their self-advocacy to what is fair and equitable for all (45). The focus of this debate must center on the best interest of the patient, without failing to recognize that every individual is also a member of society. If a physician believes, after carefully considering the patient's medical status, values, and goals, that a particular medical treatment is futile because it violates the principles of beneficence and justice, then the physician is ethically and professionally obligated to resist administering this treatment. This justification of medical treatments on the basis of physiological effectiveness, weighing the benefits and burdens, and the appropriate use of medical resources, is firmly rooted in the history of medicine and ethical tradition.

## CONCLUSION

For years physicians have been criticized for being reluctant to admit to patients that death was imminent. Death has been viewed by the medical profession as the enemy and the ultimate failure to be defeated. In the past, physicians tried to overcome the obstacle of death by trying a new technology or a new medication. Any medical alternative was better than facing the inevitability of death. However, with the passage of time, a number of voices within the medical and ethical establishment began to challenge physicians to see that a peaceful, dignified death was a medical ideal just as important as prolonging and extending life. Acceptance of this new ideal has led physicians to strike a balance between aggressive treatment and palliative care. As part of this balance, physicians have come to realize that in the process of any disease there is a point when further treatment is nonbeneficial and not in the patient's best interest. This new sense of realism about death and nonbeneficial treatments has been the cornerstone of the futility debate.

The futility debate is complex because it incorporates not only medical components, but also social, ethical, and legal components. Physicians are not medically, ethically, or legally obliged to offer a patient medical treatments which they believe to be nonbeneficial or inappropriate. "The ethical obligation of beneficence and the legal obligation of "due care" require that the physician exercise appropriate clinical judgment, consistent with appropriate professional standards, in pursuit of the health and well-being of the patient (46). One of the major problems facing physicians in regard to medical futility decisions is fear of legal liability. "The evolution of case law in medical futility is still in its early stages, and the reaction from the courts has been mixed. In fact, it appears that the lower courts would rather not handle this complex problem at all" (47). The major concern of physicians seems to be that hospitals have no policies that will support them in the event that they decide to deny treatment deemed medically futile. Until the concept of futility is clarified and ethical policies are formulated, physicians will continue to comply with patient's/surrogate's requests for medically inappropriate treatments because the fear of malpractice hangs over their heads like the sword of Damocles.

Observing pediatricians and neonatologists capitulate to the demands of parents and family members for medically futile treatments, it became clear that there is a need to formulate a public policy on medical futility in general, but more specifically for Pediatrics and Neonatology because of their excessive costs, that would address these concerns. Various types of futility policies were examined, and after careful review it became clear that since there was no consensus on a substantive definition of futility, a process-based approach for determining futility on a case-by-case basis was more appropriate. The policy that is being proposed for Pediatrics and Neonatology is based on the Houston Process-Based Approach because it seemed to be the most practical to implement (48). After consultation with various pediatricians, neonatologists, nurses, etc., a similar procedural policy was designed that is medically appropriate and firmly rooted in the respect for human persons. However, in the process of this design, it became apparent that a futility policy must dovetail with a Palliative Care Policy so that it would be very clear that even though it may be determined that a specific treatment is medically futile, health care professionals will never abandon a patient. Each patient will be given appropriate care and will be treated with the utmost dignity and respect. The duty of a health care professional is to offer patients those treatments which will be beneficial to them. These treatments should restore their health, cure when possible, relieve pain and suffering, provide comfort care, and improve their quality of life. The test of beneficence is whether or not physicians can achieve these goals, not just any goals or any interests (49).

This author believes that the medical futility policy entitled: "Proposed Policy on the Determination of Medically Inappropriate Medical Treatment" (appendix), can be advanced as a public policy option that will assist physicians in providing patients with medical treatments which are in their best interest, will foster a responsible stewardship of health care resources, and will provide the courts with a fair standard to be used in adjudicating these cases. This public policy option is not perfect, but it is a big step forward toward improving end-of-life care for children and assisting parents and physicians to do what is in the best interest of the child.

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3. In medical futility cases the patient or surrogate wants to pursue the goal of preserving life even if there is little chance or no hope of future improvement, while the other party, the physician, sees dying as inevitable and wishes to pursue the goal of comfort care. For a more detailed analysis, see Council of Ethical and Judicial Affairs, American Medical Association, "Medical Futility In End-Of-Life Care," J. Am. Med. Assoc. 281 (March 10, 1999): 937-41.

4. The two prominent cases here would be the Helga Wanglie case and the Baby K case. For a more detailed analysis of both cases, see *In re Helen Wanglie*. Fourth Judicial District (District Court Probate Court Division) PX-91-238. Minnesota, Hennepin County; and *In re Baby K*, 16 F. 3d 590, petition for rehearing en banc denied, no. 93-1899 (L), CA-93-68-A, 28 March 1994. It should be noted that in the Wanglie case the court never addressed the question of whether physicians or the medical center could refuse to provide requested treatment, and thus the conflict between nonmaleficence and beneficence and autonomy was not resolved. The court ruled that Mr. Wanglie should be appointed his wife's conservator on the grounds that he could best represent his wife's interests.

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6. "Acting in the 'best interest' of another implies taking certain steps or following certain rules so that the person and his or her concrete human community will survive and potentially flourish. 'Survival' is a minimal yet essential consideration. It requires no vision beyond maintaining the existence of the person and his or her specific community of shared value or good. 'Flourishing' is the fulfillment of a person's potential for purposeful existence within a community of choice. 'Human flourishing' is more complex than survival because it implies movement beyond mere existence and thus requires some shared purpose, or telos, as a standard or direction for the individual and his or her community to pursue. To flourish is to pass from mere survival to active participation in and enjoyment of the goods and values of at least one specific social group-that is, to move from merely being alive as an individual to creatively living within a community.

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Judicial Affairs published "Guidelines for the Appropriate Use of Do-Not-Resuscitate Order." The Council held that CPR may be withheld, even if previously requested by the patient, "when efforts to resuscitate a patient are judged by the treating physician to be futile." See American Medical Association, Council on Ethical and Judicial Affairs, "Guidelines for the Appropriate Use of Do-Not-Resuscitate Orders, *J. Am. Med. Assoc.* 265 (1991): 1870. In 1991, the American Thoracic Society took a similar stand and claimed that "forcing physicians to provide medical interventions that are clearly futile would undermine the ethical integrity of the medical profession." See American Thoracic Society, Bioethics Taskforce, "Withholding and Withdrawing Life-Sustaining Therapy," *Ann. Int. Med.* 115 (1991): 478-85. Finally, in 1993, the Ethics Committee of the Society of Critical Care Medicine specified severe, irreversible brain damage, irreversible multi-organ failure, and metastatic cancer unresponsive to treatment as categories of "patients who may be excluded from the ICU, whether beds are available or not." The Committee also designated "patients who should be excluded as those who refuse intensive care, who are brain-dead, and are in a permanent vegetative state." See Task Force on Ethics of the Society of Critical Care Medicine, "Consensus Report on the Ethics of Forgoing Life-Sustaining Treatments in the Critically Ill," *Crit. Care Med.* 18 (1993): 1436.

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27. Reference 22, 227-228. It should be noted that decision making about what kinds of medical care to give to a patient is not solely in the hands of the physician. There are other factors that must be considered in the decision-making process such as: whether the patient is in a managed care setting and therefore, some treatments may not be widely available or supported, considerations of insurance and malpractice, the kinds of populations being served by the physician.

28. According to ethicist Gerald Kelly, S. J. and his classic interpretation of the ordinary/extraordinary means distinction in the Catholic tradition: "ordinary means of preserving life are all medicines, treatments, and operations, which offer a reasonable hope of benefit for the patient and which can be obtained and used without excessive expense, pain, or other inconvenience, Extraordinary means are all medicines, treatments, and operations, which cannot be obtained or used without excessive expense, pain, or other inconvenience, or which, if used, would not offer a reasonable hope of benefit." Kelly, G. *Medico-Moral Problems*. St. Louis, MO.: The Catholic Health Association of The United States And Canada, 1958, 129. Emphasis in the original.

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## **Ethics and Medical Futility: the Healthcare Professional's Role Is Care Ever Futile?**

Barbara Resnick, PhD, CRNP

Ethics, or ethical care, refers to a framework or guideline for determining what is morally good (i.e., right) or bad (i.e., wrong). Ethical problems arise when there is conflict about what is the "right" thing to do. This can and does occur when decisions need to be made around whether a medical intervention is futile. What is the right or wrong thing to do here? The answer to this straightforward question, unfortunately, is never easy and involves a complex integration of thoughts, feelings, beliefs, and evidence-based data.

Many experts advise against the use of the term "futile care," especially with families. *Care* is never futile, but *medical interventions* sometimes are. This was a central theme of Marnie Ritchie Poncy, RN, ESQ, of the Bioethics Law Project, Legal Aid Society of Palm Beach County, Inc., Palm Beach, Florida, in her presentation.<sup>[1]</sup> Ms. Poncy stressed the importance of nurses in helping patients determine whether medical interventions are futile and in determining their end-of-life care decisions.

Medical futility is described as proposed therapy that should not be performed because available data have shown that it will not improve the patient's medical condition.<sup>[2]</sup> Medical futility remains ethically controversial for several reasons. Some healthcare providers claim that a treatment is futile without knowing the relevant outcome data. There is, unfortunately, no consensus as to the statistical threshold for a treatment to be considered futile.

Legal language within these doctrines encourages the use of *judgment*, which may conflict with medical decision making. Medical decisions are generally based on prevalence and risk associated with conditions and known chances of obtaining a specific outcome. Moreover, there can be disagreement between healthcare providers and families in regard to the benefits to the patient of continued treatment.

To avoid medical futility disputes, Poncy<sup>[1]</sup> recommends that we take a proactive approach and make sure that all individuals engage in advance care planning. This type of planning moves beyond developing a living will and/or establishing a power of attorney for healthcare decisions.

### **Advance Care Planning**

Specifically, advance care planning is a term used for the process of preparing for end-of-life issues and ideally includes the completion of a living will, a durable power of attorney for healthcare (DPAHC), and specific end-of-life treatment preferences (ELTP). Historically, living wills allowed patients to direct healthcare providers to withhold or withdraw life-sustaining treatment if they became terminally ill. Currently these provisions vary from state to state in regard to whether the patient must be terminally ill, or whether the directive within the living will can be implemented under other circumstances.

The important difference, however, between a living will and a DPAHC is that the living will gives instructions about end-of-life care preferences *without* appointing an agent. In contrast, a DPAHC is a legal document that allows individuals to designate a person to make medical decisions for them if they are unable to do so. The DPAHC is less specific than a living will and applies to all situations in which patients are incompetent and unable to make their own decisions.

## ELTP

Determination of ELTP focuses more specifically on decisions about the care received at the end of life. In order for a healthcare provider and designated power of attorney to be appropriate advocates for the older patient and to accurately carry out their care preferences at the end of life, ELTP must be clearly addressed and described prior to an acute event. "This is a gift," I tell my patients, that they can leave for their family members. It will assure that the family feels comfortable and confident that they have carried out the preferences of their loved one.

The Figure provides an example of a personally written letter describing the end-of-life care preferences of an older woman, written at the time of her move to a continuing care retirement community 20 years ago. Ms. Poncy<sup>[1]</sup> recommends that all individuals complete an Advance Directive/End of Life Plan of Care form that delineates end-of-life care preferences.<sup>[3]</sup>

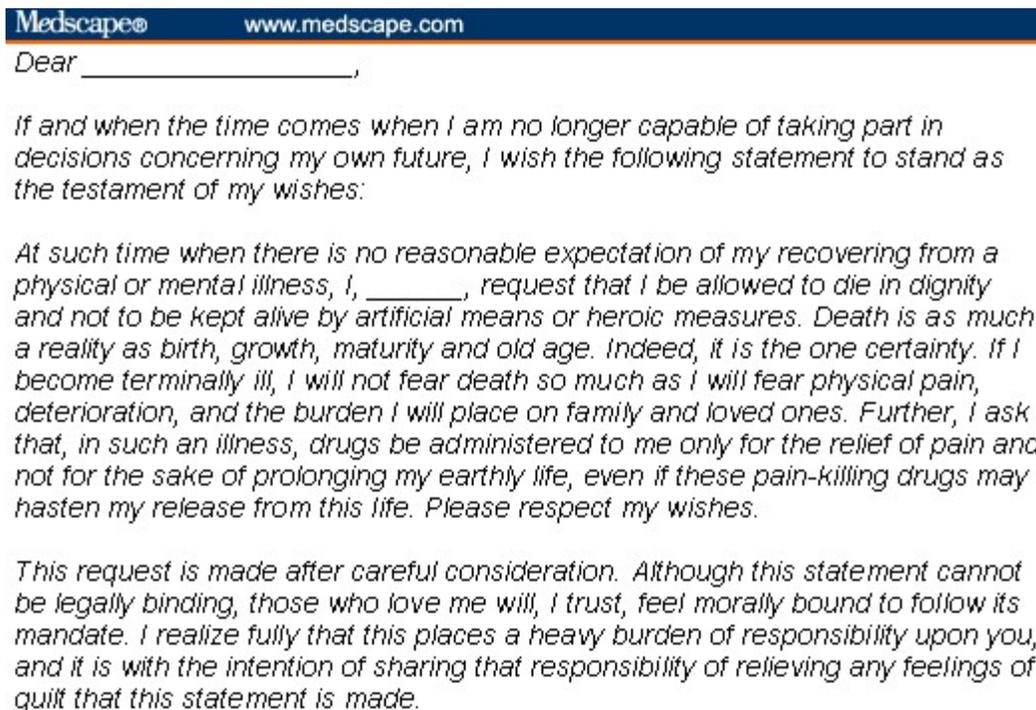


Figure 1. **Sample letter: end-of-life care preferences.**

### **Additional Interventions to Prevent Futile Interventions**

Additional ways to reduce the occurrence of futile medical interventions include improving the communication that occurs between healthcare providers and patients or their proxies. Healthcare providers need to provide families with accurate, current, and frequent prognostic estimates; address the emotional needs of the family; and try to understand the problem from the family's perspective.

More than anything, healthcare providers need to assure families that *everything* is being done for their loved one. The "everything," however, is everything possible related to comfort and optimizing dignity at the end of life.

Prior to talking with a family/proxy, it is critical that the healthcare team agrees with the information being provided so that the family is not confused by hearing different options and opinions. The options should always include a choice of comfort care, and a reminder to the family/patient that refusing a medical intervention does not mean that no care or no further treatment will be given.

Any information that we have as healthcare providers related to the patients' end-of-life care preferences should be documented in the chart and shared repeatedly with the family/proxy. This can provide an important sense of reassurance to the family/proxy that they have done what the individual wanted.

In the event that a family/proxy wants to continue to explore a treatment option that you as the healthcare provider believe will be "futile," it is important to encourage the patient/family/proxy to explain their rationale. This ongoing discussion may help express concerns around things, such as culturally specific issues, and/or clarify any misunderstandings. For example, in some cultures it is believed that the individual cannot get into heaven on an empty stomach. Therefore, the placement of a feeding tube would take on a different meaning than it might for someone with a Judeo-Christian philosophy.

It may also be helpful to provide the family/proxy with information about palliative care resources, such as hospice care or chaplain services, and again reiterate that the alternative choice to not accepting the treatment is comprehensive care focused on comfort and optimizing the quality of remaining life.

### **The Ethics of Medicine**

As healthcare providers, we may feel uncomfortable about encouraging patients/families/proxies to consider the option of saying no when we believe that medical intervention is futile. It could be argued that this is the patient's/family's/proxy's right to decide.

The ethics of medicine, which is based on principlism,<sup>[4]</sup> helps provide guidance around these difficult decisions. Principlism includes 4 principles -- autonomy, beneficence, nonmaleficence, and justice -- and is geared toward maximizing benefits over harm and doing the greatest good for the greatest number. *Autonomy* is assumed to be the highest good and involves allowing the individual to make his or her own decisions. *Beneficence* is focused on doing good, and *nonmaleficence* is focused on doing no harm. Justice is the ideal and morally correct state of things and persons. *Justice* involves consideration of the entire community and what is best for all.

Using healthcare resources to provide a medical intervention that prolongs life but may worsen the quality of that life may not be the best decision for the community at large. Ms. Poncy strongly urges that providers have a duty to inform patients/families/proxies about the known anticipated outcomes of care, and when medically futile, palliative interventions should be initiated so as to conserve resources for the entire community.

### **Moving From DNR to AND**

The 1990 Patient Self Determination Act (PSDA) has encouraged healthcare providers to ask patients about their advance directive and establish whether the patient requests a do-not-resuscitate (DNR) order. There is a new trend emerging, however, for healthcare providers to encourage patients to declare an acceptance of natural death (AND) request when medical interventions are deemed medically futile. Increasingly, we will see these decisions noted on charts within all healthcare settings.

As healthcare providers, we have the honor and privilege of working with individuals at the end of life. Ethically, we should encourage all individuals to declare their end-of-life care preferences and identify a proxy in the event that they are no longer deemed competent. We must also, in the interest of the

entire community in which we live, provide patients/families/proxies with known information about the potential outcomes of medical interventions and always offer the alternative of exemplary comfort care-related interventions at the end of life.

## **“Doc Knows Best” It’ll be too late for you, if he’s wrong.**

By Wesley J. Smith

Who should have the right to decide whether you receive life-sustaining medical treatment during a critical or terminal illness? Most would say with great confidence, "Me. Or, if I am unable to decide, then my family."

That should be true. Indeed, it used to be true. But in a growing number of hospitals, your right-to-decide is being taken away from you (or your family) by bioethicists and members of the medical intelligentsia who believe that *their* values and priorities should count more than yours when determining whether you shall receive wanted medical treatment. To put it bluntly, even if you *want* to live, even if you *want* medical treatment to enable you to fight for your life, you may be told that the hospital reserves the right to refuse service.

Welcome to the world of "futile-care theory," one of the hottest and most-dangerous topics in contemporary bioethics. While you may never have heard of it, stories about the spread of futile-care theory are rife throughout medical and bioethics literature, reported and argued about in such influential publications as *The Journal of the American Medical Association*, *The New England Journal of Medicine*, and *The Hastings Center Report*.

Unfortunately, few people read these highbrow publications. Worse, despite being a bombshell story, this growing threat has mostly been ignored by the popular media.

This better change fast. As you read these words, quietly, slowly, inexorably, mostly behind the closed doors of hospital ethics committees, "futile care" or "inappropriate care" protocols are being put into place in hospitals throughout the country. The first time most patients and their families become aware that doctors are being given the right to say "no" to wanted medical treatment (other than comfort care) is during a medical crisis when they are at their most defenseless and vulnerable.

Hospitals in Des Moines, Iowa, appear to be the latest institutions to stealthily adopt futile-care policies. As reported by the January 2, 2003, *Cedar Calls Courier*, some area hospitals now have rules in place that permit "medical staff to withdraw treatment over a family's objection." True, when there is a dispute, families and patients have a right to a hearing in front of a hospital ethics committee. But that isn't much solace. Such committees could easily become more stacked decks than dispassionate

decision makers, mostly comprised of well-meaning people who either are part of the institutional culture or who have been trained to believe that futile-care theory is the right thing to do.

According to the *Courier* report, if patients lose the right to receive treatment in the ethics committee, they have two choices. First, they can find another hospital. But this would be no easy task given that patients refused treatment are likely to be the most expensive to care for. With the coming of HMOs, and the Medicare Diagnosis Related Group (DRG) capitated payment system, hospitals now generally lose money on patients requiring intensive or extended care. Thus, getting another hospital to accept a patient that a current hospital doesn't want to treat anymore may be a near impossible task.

That leaves the courts and filing a lawsuit to force the hospital to sustain the patient's life. That could work, but it is no sure bet.

There have been lawsuits filed in various parts of the country over refused treatment, but the results have gone both ways. Moreover, no definitive case has yet been litigated to the appeals court stage. Thus, there are no legal precedents governing the legality or permissible scope of these quickly spreading futile-care policies.

But even though a lawsuit could be successful in theory, it might very well prove utterly impracticable to pursue. These are not the kind of cases that lawyers accept on a contingency basis. This means that if you try to legally force a hospital to continue treatment, you would probably have to pay your lawyer by the hour. Lawyers often charge hundreds of dollars an hour, meaning that a fully litigated case, even without appeals, could cost literally tens, if not hundreds of thousands of dollars.

On the other hand, having very deep pockets, the hospital administration would not be concerned in the least about the cost of their lawyers. If fully unleashed, the hospital's corporate lawyers could file enough motions, take enough depositions, and pursue every possible appeal, to the point that you, quite literally, could litigate yourself into bankruptcy.

Beyond the financial impracticalities of suing a hospital, one of the primary reasons for crafting futile-care protocols has been to improve the chance that the hospital would prevail in court. Indeed, an article in the Fall 2000 *Cambridge Quarterly of Health Care Ethics* explicitly advised hospital bioethicists to put these protocols in place as a way to prepare for the litigation bioethicists presume would be filed by people furious at having wanted medical treatment refused. As the authors of *The Cambridge Quarterly* article opined, "Hospitals are likely to find the legal system willing (and even eager) to defer to well-defined and procedurally scrupulous processes for internal resolution of futility disputes."

Nobody knows just how many hospitals have adopted these protocols, or where they have been put in place. But if the professional literature is to be believed, futile-care theory is spreading quickly. The *Cambridge Quarterly* article cited above found that 24 out of 26 surveyed hospitals in California had such policies in place and that of these; only seven left the final decision to the patient or family. I have read about policies being adopted by some hospitals in Houston, Philadelphia, and Detroit, just to mention a few.

It used to be that people were afraid of being hooked up to machines when they wanted nothing more than to go home and die a peaceful, natural death. The early bioethics movement deserves great thanks for helping do away with that form of abuse by pointing out that patient autonomy means the right to say no to unwanted interventions.

But that was before the bioethics movement largely abandoned the sanctity of life ethic for an express or implicit utilitarianism that views the value of human life through a distorting prism of "quality." That was before most bioethicists came to believe that health-care rationing should be imposed.

Now, a new medical hegemony is arising, one that proclaims the right to declare which of us have lives worth living and therefore worth treating medically, and which of us do not. In essence, what is being created in front of our very eyes (if we would only see) is a duty to die. Unless people object strongly and legislatures take active steps to intervene, this new and deadly game of "Doctor Knows Best" will be coming soon to a hospital near you.

## **Medical futility: legal and ethical analysis**

by Peter A. Clark, SJ, PhD  
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For the past decade a debate has been raging within the medical, ethical and legal communities on the concept of medical futility. Despite its emergence as a dominant topic of discussion, especially as it applies to end-of-life care, the concept of medical futility is not new. Physicians at the time of Hippocrates recognized some medical conditions as impossible to cure and recommended no further treatment for those patients [1]. What has fueled the fires of the current multifaceted debate is the patients' rights movement and the perception that the right of self-determination extends not only to the refusal of medical treatments but to demands for overtreatment [2].

The patients' rights movement began as a reaction to the paternalism of physicians who unilaterally overtreated patients and prolonged their lives against their wishes or the wishes of their surrogate decision makers and family members. The perception of physician-driven overtreatment resulted in a series of legal cases ranging from the Quinlan case in 1976 to the Cruzan case in 1990, which gave patients or their appropriate surrogates the legal right to refuse medical treatment, even if doing so resulted in the patient's death. Despite physician or hospital administration arguments that treatment was appropriate, the courts ruled in favor of the patient's right to refuse treatment and the patient's surrogate's right to withhold treatment, generally on the condition that there was clear and convincing evidence that the patient would refuse life-sustaining treatment if he or she were conscious and able to do so.

In the 1990s, patients and patient surrogates began demanding treatments that physicians believed were *not* in the best interest of the patient because they were medically futile and represented an irresponsible stewardship of health care resources. In legal cases such as Wanglie in 1991 and Baby K in 1994, the courts ruled in favor of the right of patients or their surrogates to request even those medical treatments from which physicians believed they would receive no medical benefit [3]. What has been problematic for the judges in these cases has been the lack of professional or institutional policies on medical futility against which they could judge physician and hospital compliance or noncompliance [4]. These complex cases have set the stage for the present debate over medical futility, which pits patient autonomy against physician beneficence and the allocation of social resources.

Patients and surrogates make the ethical argument that, if they have the right to refuse or discontinue certain medical treatments on the basis of their best interest, they have the right to request certain medical treatments on that same basis. Physicians argue that many of the requested interventions are both burdensome for the patient and medically inappropriate because they fail to achieve the desired physiological effect and result in a misallocation of medical resources. Although providing these treatments can compromise physicians' professional integrity, many feel compelled to comply with the patient's or surrogate's wishes because they believe that society has mandated the provision of such interventions unless there is an agreement to withhold them [5]. The ever-present fear of litigation has not only fueled this debate, it has placed the very foundation of the patient-physician relationship in jeopardy.

The position of absolute patient autonomy ignores the fact that a well-established "best interest" standard assumes both a connectedness of the patient to family and physician and a communication process that allows surrogates to take into account objective, community-based best interest standards [6]. A resolution of these concerns will have to avoid both the traditional physician-driven overtreatment and recent patient- and patient surrogate-driven overtreatment by balancing patient/surrogate rights with physician/societal rights [7]. From an ethical and a legal perspective, one way to foster this balance is to apply a process-based approach to futility determinations on a case-by-case basis. The goal of a process-based approach would be a medical futility policy that protects the patient's right to self-determination, the physician's right of professional integrity and society's concern for the just allocation of medical resources and is securely rooted in the moral tradition of promoting and defending human dignity.

### **Legal implications**

Perhaps one of the biggest challenges in implementing a futility policy is recognition by physicians and health care institutions that adopting such a policy carries with it the threat of litigation. Texas took the lead in addressing the issue of medical futility from both a medical and legal perspective. In 1999, Texas legislation combined three preexisting laws regulating end-of-life treatment into a single law, the Texas 'Advance Directives Act.' This law established a legally sanctioned extrajudicial process for resolving disputes about end-of-life decisions. This mechanism for dispute resolution may be used in response to a surrogate, living will, or medical power of attorney request to either "do everything" or "stop all treatment" if the physician feels ethically unable to agree to either request [8].

The Texas law became a model for other states and for individual hospitals seeking to make changes in statutory regulations and institutional policies regarding end-of-life treatment decisions. Futility policies are a relatively new initiative in health care, and there was uncertainty as to how the courts would respond when confronted with a "futile treatment" case.

The Texas law was tested in March 2005 when Sun Hudson, born with thanatophoric dysplasia, a typically fatal form of congenital dwarfism, was removed from a breathing tube against the wishes of his mother, Wanda Hudson. The breathing tube was removed pursuant to Chapter 166 of the Texas Health and Safety Code, the Advance Directive Act [9]. Under this act, the doctor's recommendation to withdraw support was confirmed by the Texas Children's Hospital ethics committee. Although it is not required under the act, Texas Children's Hospital took the extra step of getting a judge to rule on its decision. The judge found that the act authorized the hospital to withdraw life support over the objection of the baby's mother.

Wanda Hudson was given 10 days from receipt of written notice to find a new facility to accommodate Sun if she disagreed with the hospital decision, but she was unable to find another facility. Texas Children's Hospital stated that it attempted to contact 40 facilities, but it, too, was unable to find one willing to accept the boy.

On March 15, 2005, physicians at Texas Children's Hospital sedated Sun for palliation purposes and removed the breathing tube; he died within a minute [10]. This was the first time a hospital in the United States had allowed removal of life-sustaining support against the wishes of the legal guardian, and it became a precedent-setting case that should help relieve some of the anxiety of physicians and hospital administrators about invoking a medical futility policy in future cases. It appears that the court acted in the best interest of the patient—who doctors said was certain to die and most likely to suffer before doing so—using a process-based approach.

One of the goals in implementing a futility policy is to facilitate communication between the patient or surrogate and the health care staff so that all parties can come to an acceptable agreement regarding the proposed treatment. If agreement is not reached between the physician or hospital and the patient or surrogate, either party may seek injunctive relief from the courts, or the patient/surrogate may file medical malpractice action.

Physicians are particularly adverse to litigation. The physician who loses a malpractice claim risks damage to his or her professional reputation and the possibility of an increase in malpractice payment premiums. Perhaps even more dreaded though, is the report that will be filed with the National Practitioner Data Bank confirming that the physician lost a medical malpractice suit [11]. A data bank report will follow the physician for the remainder of his or her career, since all hospitals are mandated to query the data bank on a regular basis. Even the physician who prevails in a professional malpractice action expends substantial time defending himself by meeting with attorneys, answering interrogatories, appearing for deposition and testifying at trial. Obviously then, the threat of litigation alone will deter some physicians from ever invoking a futility policy.

For those physicians who are willing to risk litigation for the sake of preserving their professional integrity, a futility policy offers legal benefits. Although a futility policy will not insulate a physician from litigation, it should enable him or her to fashion a strong defense in a medical malpractice claim. As a general rule, to prevail in a professional malpractice action the plaintiff must establish that the harm he or she suffered resulted from the physician's having breached the standard of care. Implementing a futility policy requires consensus from other physicians and other interdisciplinary committees within the institution that the proposed treatment is not beneficial to the patient. Such a consensus among physicians can then be submitted as evidence in legal proceedings to demonstrate that the standard of care was not breached.

Implementation of a futility policy may also give rise to claims for injunctive relief. The patient or surrogate may file an action asking a court to order that the "futile" treatment be administered. Likewise, a physician or institution may petition the court for an order that futile treatment not be initiated or, if already initiated, be discontinued, as in the Wanglie case [12]. If the physician has withheld or discontinued treatment in accordance with the institution's futility policy, the court may be more inclined to conclude that the treatment is, indeed, inappropriate.

### **Ethical implications**

Futility is defined as "inadequacy to produce a result or bring about a required end; ineffectiveness" [13]. Medically, the concept of "futility," according to the American Medical Association, "cannot be

meaningfully defined” [14]. Essentially, futility is a subjective judgment, but one that is realistically indispensable [15]. There is consensus within the medical community that at specific times during the course of an illness some treatments are medically futile; consensus ends however, when attempts are made to formulate a fully objective and concrete definition. As a result, futility has been confused with interventions that are harmful, impossible and ineffective. Distinguishing futility from the concept of harmful and ineffective interventions has led to some clarity. In general, a medically futile treatment is an action, intervention, or procedure that might be physiologically effective in a given case, but cannot benefit the patient, no matter how often it is repeated. A futile treatment is not necessarily ineffective, but it is worthless, either because the medical action itself is futile (no matter what the patient’s condition) or the condition of the patient makes it futile [16].

But until we have a more clear understanding of what medical futility means at the bedside, there will not be widespread agreement on definitions and implications of futility in general [17]. Ethicists Baruch Brody and Amir Halevy have distinguished four categories of medical futility that set the parameters for this debate. First, physiological futility, also known as quantitative futility, applies to treatments that fail to achieve their intended physiological effect. These determinations are based not on vague clinical impressions but on substantial information about the outcomes of specific interventions for different categories of illness states. The second category, imminent-demise futility, refers to those instances in which, despite the proposed intervention, the patient will die in the very near future. (This is sometimes expressed as “the patient will not survive to discharge,” although that is not really equivalent to dying in the very near future.)

Brody and Halevy use the third term, lethal-condition futility, to describe those cases in which the patient has a terminal illness that the intervention does not affect and that will result in death in the not-too-distant future (weeks, perhaps months, but not years) even if the intervention is employed. The fourth category, qualitative futility, refers to instances in which an intervention fails to lead to an acceptable quality of life for the patient [18]. When a treatment is judged to be qualitatively futile, the claim being made is that, although the treatment may succeed in achieving an effect, the effect is not worth achieving from the patient’s perspective [19].

Medically, a consensus concerning the clinical features of medical futility remains elusive. Ronald Cranford’s conclusion is representative: “Whatever futility means, it seems obvious that this is not a discrete clinical concept with a sharp demarcation between futile and non-futile treatment” [20]. Brody and Halevy’s four categories emphasize that decisions on medical futility must be made on a case-by-case basis and must include both a substantive component and a role for patient and surrogate input. Determining whether a medical treatment is futile basically comes down to deciding whether it passes the test of beneficence; that is, will this treatment be in the patient’s “best interest”? The test of beneficence is complex because determining whether a medical treatment is beneficial or burdensome, proportionate or disproportionate, appropriate or inappropriate, involves value judgments by both the patient and the physician.

### **The Catholic perspective**

The medical futility debate is, at bottom, a conflict between respect for patient autonomy, on one hand, and physician beneficence and distributive justice, on the other. In seeking a balance between the values and goals of the patient and the values and goals of medicine, individual autonomy cannot be so inflated in importance as to destroy the principle of beneficence and overlook the equitable distribution of medical resources in society. To find the balance, physicians must reach a consensus on what constitutes a reasonable medical treatment, and patients and surrogates must restrict their self-advocacy to what is fair and equitable for all [21]. The reasonable treatment decision must center on

the best interest of the patient, without failing to recognize that every individual is also a member of society. If a physician believes, after carefully considering the patient's medical status, values and goals, that a particular medical treatment is futile because it violates the principles of beneficence and justice, then the physician is ethically and professionally obligated to resist administering this treatment.

The justification of medical treatments on the basis of weighing the benefits and burdens and the appropriate use of medical resources is firmly rooted in the Catholic moral tradition of the ordinary versus extraordinary means distinction.

Various church documents from *Veritatis Splendor*, to the Pontifical Academy of Life's *Respect for the Dignity of the Dying* to *Evangelium Vitae* make it quite clear that individual autonomy is not an absolute. Pope John Paul II applied this principle to medical treatments in *Evangelium Vitae* when he stated: "Certainly there is a moral obligation to care for oneself and to allow oneself to be cared for, but this duty must take account of concrete circumstances. It needs to be determined whether the means of treatment available are objectively proportionate to the prospects of improvement" [22]. The Catholic tradition maintains that if a medical intervention is judged to be ordinary it is viewed as morally mandatory. If extraordinary, it is morally optional. It is said to be ordinary if it offers a reasonable hope of benefit for the patient and could be used without excessive inconvenience, which includes risk, pain and expense. If it offers no reasonable hope or benefit or is excessively burdensome, it is extraordinary [23].

Pius XII further clarified the ordinary versus extraordinary means distinction when he declared that "we are morally obliged to use only ordinary means to preserve life and health—according to circumstances of persons, places, times and culture—that is to say means that do not involve any grave burden for oneself or another" [24]. Pius XII bases the distinction between ordinary and extraordinary means on the idea that human life is a basic good, but a good to be preserved precisely as a necessary condition for existence of other values. One must examine the circumstances of a particular situation, which include cost factors and allocation of resources, because these circumstances dictate the balance to be considered between life and these other values. Due to the imprecision of the terms ordinary and extraordinary and the rapid advances in medicine and technology, the Catholic Church now speaks of proportionate and disproportionate means. In determining whether a medical treatment is beneficial and proportionate, the Congregation for the Doctrine of the Faith in *The Declaration on Euthanasia* concludes that, "...it will be possible to make a correct judgment as to the means [proportionate or disproportionate] by studying the type of treatment being used, its degree of complexity or risk, its cost and possibilities of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources [25].

This statement, which is rooted in the Catholic tradition, gives physicians the ethical justification to refuse medical treatments if they are either gravely burdensome or medically futile for the patient.

Catholic hospitals are called to embrace Christ's healing mission, which means they must offer patients those treatments that will be beneficial to them. These treatments should restore their health, cure them when possible, relieve pain and suffering, provide comfort care, and improve quality of life. The test of beneficence is whether or not physicians can achieve these goals, not just any goals or any interests [26]. A process-based futility policy will assist physicians in providing patients with medical treatments that are in their best interest, will foster a responsible stewardship of health care resources, and will provide the courts with a fair standard to be used in adjudicating these cases.

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3. The two prominent cases here would be the Helga Wanglie case and the Baby K case. For a more detailed analysis of both cases, see *In re Helen Wanglie*. PX-91-238 Minn Dist Ct, Probate Division, 1991; and *In re Baby K*, 16 F3d 590, *Petition for Rehearing en banc Denied*, no. 93-1899 (L), CA-93-68-A, March 28, 1994. It should be noted that in the Wanglie case the court never addressed the question of whether physicians or the medical center could refuse to provide requested treatment, and thus the conflict between nonmaleficence and beneficence and autonomy was not resolved. The court ruled that Mr. Wanglie should be his wife's conservator on the grounds that he could best represent his wife's interests. In the Baby K case physicians and ethics committees argued in Virginia that providing certain treatments such as mechanical ventilation to an anencephalic newborn was "futile" and "would serve no therapeutic or palliative purpose," and was "medically and ethically inappropriate." The courts ruled against them.
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10. Associated Press. *Baby at Center of Life Support Case Dies*. March 15, 2005. <http://www.msnbc.msn.com/id/7190468/>. Accessed April 16, 2007.

11. The Health Care Quality Improvement Act requires professional liability insurers to report payments made on behalf of physicians to the National Practitioner Data Bank provided the payment is \$10,000.00 or greater. See USCS, 11131-11137.
12. *In re Wanglie*, No PX-91-283 (Minn. Dist Ct, Probate Ct Div July 1, 1991).
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23. According to ethicist Gerald Kelly, SJ, and his classic interpretation of the ordinary/extraordinary means distinction in the Catholic tradition: “ordinary means of preserving life are all medicines, treatments, and operations, which offer a reasonable hope of benefit for the patient and which can be obtained and used without excessive expense, pain, or other inconvenience, *Extraordinary* means are all medicines, treatments, and operations, which cannot be obtained or used without excessive expense, pain, or other inconvenience, or which, if used, would not offer a reasonable hope of benefit.” Kelly G. *Medico-Moral Problems*. St. Louis, MO: The Catholic Health Association of the United States and Canada; 1958:129. Emphasis in the original.

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## **Addressing Medical Futility Without the Hippocratic Pitfall of Paternalism**

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### **Introduction**

The improvement of life-saving treatments has led to an expansion of both choice and conflict. Since the end of World War II, the balance of power in medicine has shifted from physician to patient to managed care organization and from paternalism to bureaucratic parsimony,<sup>1</sup> and created an entirely new set of disputes in the field.<sup>2</sup> The concept of medical futility is one such area where dispute is likely and where psychiatrists have a role to play.

### **Evolution of the Doctor-Patient Relationship**

In the Hippocratic tradition, greater weight was given for the paternalistic authority of the physician to achieve the patient's best interests. The physician's pledge of beneficence and nonmaleficence added integrity to that authority. The Nuremberg Code was developed in 1947 during the Doctors' Trial, which examined Nazi physicians who conducted inhumane experiments on concentration camp prisoners.<sup>3</sup> The code signaled a fundamental change in the doctor-patient balance of power, shifting the relationship to a patient-centered approach. Although contractual on the surface, the doctor-patient relationship is more fiduciary and covenantal.<sup>4</sup>

In the fee-for-service treatment setting, the physician operates in the best interest of the patient, but in managed care, the practitioner serves other interests as well. Given a finite level of resources, cost will continue to be a legitimate concern for the patient, practitioner, and the public. Past inequities and unjust practices ensure that the collaborative relationship between patient and physician risks becoming adversarial. As a result, practitioners must be able to identify genuine choices for the patient and mediate the inevitable conflict.

## **Autonomy, Abandonment, and Futility**

Central to the ethics of medical decisions are two elements. First is individual autonomy, the competent person's right to self-determination, including the right to refuse necessary care. The second element, the physician's duty not to abandon, requires that the physician not arbitrarily sever the relationship with the patient and that he or she act in the patient's best medical interest.<sup>5</sup> If the patient refuses a necessary treatment as a direct result of cognitive impairment, it is abandonment for the physician to simply acquiesce. Similarly, if a patient has sought genuinely futile treatment out of misinformation or delusional beliefs, it would be abandonment to provide unnecessary or inappropriate care.<sup>6</sup>

### **Strict Definitions of Medical Futility**

The definition of futility is often not as straightforward as it seems. Decisions about life-sustaining interventions revolve around who makes the decision as well as the facts of the medical situation. Indeed, 80% of do-not-resuscitate orders are written for patients who lack the capacity to make the decision. Lo<sup>7</sup> cites four strict definitions of futility. First, there is no pathophysiologic rationale for the intervention. Second, the patient is receiving maximal treatment and the intervention is failing. For example, cardiopulmonary resuscitation (CPR) for the patient in septic shock who remains hypotensive despite maximum vasopressors, will not restore circulation. Third, the intervention has already failed. After 30 minutes of CPR, the patient remains in asystole and the intervention that has already failed need not be continued. Fourth, the intervention will not achieve the stated goals of care. For example, an obtunded hospital patient with advanced, metastatic cancer of the lung has previously stated that no further treatment is acceptable unless it has a chance of returning him home. If the patient arrests, CPR may restore circulation but only a miracle will return the patient home. Few metastatic cancer patients survive a resuscitation attempt and next to none survive free of mechanical ventilation. Although the fatality rate is not 100%, the overwhelming odds are against returning home. Physicians are not ethically obligated to operate with 100% certainty or to wait for miracles. Offering the false hope of a miracle is ethically objectionable.

### **Loose Definitions of Medical Futility**

Difficulties arise when medical futility is loosely defined. Again, Lo<sup>7</sup> cites four examples. First, the likelihood of success, although not vanishingly small, is highly unlikely. Yet interpretations of highly unlikely may be perceived as subjective, arbitrary, or unfair. An intervention with a 1% survival rate makes the possibility of success seem remote. However, if the survival rate were 2% or 5%, would the patient or family consider success "highly" unlikely? The acceptability of a probability may also be colored by the risks and potential benefits or burdens of the intervention.

Second, physicians may believe an intervention is futile when they do not expect to achieve a worthwhile goal. Obviously, what is worthwhile is a judgment and open to differences in preferences and values. Providing CPR for the terminally-ill hospital patient will not reverse the outcome of the terminal illness, but it may buy time for family members to make a final visit. Here, there is no absolute obligation to provide CPR, yet for reasons of compassion, the physician may agree to hold the do-not-resuscitate order.

Third, physicians may judge an intervention futile because the result will not provide an acceptable quality of life. For example, an out-of-hospital resuscitation of a person with dementia will leave the

survivor with more severe deficits and an objectively lower quality of life. Yet quality of life is inherently subjective. It is the patient and not the physician whose values and preferences should be used when making quality of life decisions. Physicians are more knowledgeable about the intervention and prognosis but beyond an awareness of those probabilities, the physician has no special expertise in quality of life.<sup>7</sup>

Fourth, the futility argument may be raised when the potential benefits of an intervention seem not to justify the effort or expense. Patients who develop combined multiple organ system failure (renal, hepatic, and cardiac) live longer in the intensive care unit (ICU). In such cases ICU care is not futile in that it will prolong life, though in extreme situations is unlikely to improve the patient's chances of leaving the hospital alive. In a busy hospital, ICU beds are a precious resource and a severely ill patient with organ system failure will be triaged to less intensive care. In this example, it is cost and allocation of resources rather than futility that are at stake.<sup>8</sup> Masking the cost argument as medical futility hides the sad but necessary social decisions of whose life is worth saving and at what cost.

### **Unilateral Decisions that May Be Arbitrary**

There are additional problems with the concept of medical futility. First, the physician's assessment of futility may be mistaken. It may be based on anecdotal experience, outdated training, or ignorance of recent evidence. Second, futility decisions may be inconsistent, determined by the physician's personal preference or the culture of care at the site of practice. Third, futility may be represented as scientifically based or objective and mask a value judgment inherent in any life and death decision. Such judgments are ethical, political, and social choices as well as medical.<sup>7</sup> This is not to say that the practitioner's medical values are not important or necessarily at odds with patient and family preferences. Rather, safeguards are needed to insure that the practitioner's unilateral decision is appropriate rather than arbitrary.

### **Safeguarding a Fair Approach to Futility**

Safeguards exist that may protect the physician from technical errors as well as the appearance of being unfair (Table). They also protect patients and families from the tragedy of false hope and unwanted care that arises out of lack of information and support. Lo<sup>7</sup> suggests three steps to safeguard the decision about the futility of an intervention. First, obtain a second opinion. If in agreement the second opinion can provide reassurance to the physician and other involved parties. If not, the second opinion will help clarify goals and options. Second, inform the patient and family or surrogate decision maker of the judgment. If a demand for a futile intervention is made, ask for more discussion. Questions that need to be resolved revolve around expectations of the intervention, factual errors of understanding, reason for withholding an intervention, and family needs.<sup>9</sup> Finally, establish guidelines or end points to determine the futility of the intervention. A time-limited trial of the intervention may answer the question of futility for all parties. For example, in the patient emaciated by dementia, will a month-long trial of improved nutrition via feeding tube restore a degree of independence or improve cognition? In some instances professional societies have published directives.<sup>10,11</sup> In other instances the patient's advanced directives may clarify the goals. In any event, the physician who involves others in the decision-making process without abdicating responsibility for the ultimate recommendation will be least likely to encounter difficulties.

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**Table****Avoiding the Hippocratic Pitfall of Paternalism**

- Obtain a second opinion to reinforce futility assessment or clarify goals and options
- If patient, family, or surrogates continue to demand a futile intervention, determine:
  - What is expected of the intervention?
  - Are there misperceptions about possible outcomes or the medical facts of the patient's condition or care?
  - Is the withholding of an intervention perceived to be abandonment?
  - Are there previously undisclosed family needs or patient preferences that might alter the perception of futility?
- If the physician decides to proceed with the intervention, outcomes and timelines should be strictly defined
- A psychiatric consultant can mediate conflict, foster open discussion, and support persons distressed by the realization of genuine futility

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## Conclusion

The promise of biomedical advances cannot be realized without improvements in the physician's understanding of bioethics and conflict mediation. Furthermore, the need to contain costs and achieve equitable access to the benefits of care are competing social imperatives, not passing trends. Conflict is inevitable but need not be destructive if managed with skill, fairness, and transparency. Psychiatric consultants can help mediate conflict, foster open communication, and provide emotional support for families distressed by the recognition of genuine futility.

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## **A New Approach to the Issue of Medical Futility: *Reframing the Debate***

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The 1960s saw the birth of the newest field in the ethics of healthcare and the biomedical sciences: bioethics. The revolutionary technological advances during this and the following decades – including the creation and widespread use of dialysis machines, artificial ventilators, in vitro fertilization, modern contraception, and organ transplants – created new ethical problems that had never before been encountered. As these technologies developed, people began asking questions about their proper use.

With the new capacity to keep the bodies of “dead” patients working for days, months, or even years, bioethicists had new dilemmas on their hands. By the 1980s, physicians began to identify that they could maintain physiological processes of life but not reverse existing bodily damage. In an increasing number of patients, doctors felt they were prolonging death with nonbeneficial or even harmful treatments.<sup>1</sup> This issue of medical futility has become a growing problem for hospitals; in the United States alone it is estimated that there are currently 14,000-35,000 people in a persistent vegetative state (PVS), and this number does not include the potentially thousands of other patients who are comatose but do not meet the recognized criteria for brain death.<sup>2</sup>

In this paper I will lay out the foundation of the medical futility debate, using Mark Wicclair’s article, “Medical Futility: A Conceptual and Ethical Analysis,” published in *Biomedical Ethics*, by Thomas Mappes and David DeGrazia.<sup>3</sup> After discussing some of the concerns that arise with the available literature on the futility conversation, I will develop my own working definition for medical futility. After reading this paper, I hope that doctors and bioethicists will gain a greater understanding of the difficulties of declaring a treatment futile, as well as improve their ability to consider the ethical questions raised throughout the treatment of a dying patient.

The word “futility” comes from the Latin word for leaky (*futilis*), and can be found in ancient texts such as the Greek myth of the daughters of Danaus who were condemned for eternity in Hades to draw water in leaky buckets. A futile action, as exemplified in this story, is one that will never achieve the goals of the action, no matter for how long or how often it is repeated.<sup>4</sup> To deem a medical treatment futile requires considerable clarification.

In order to understand the idea of medical futility, it is important to recognize the difference between futility and impossibility. For example, it is physically impossible to restart a heart if the person does not have enough blood in their body. Futility is also often confused with extremely complex acts that are implausible, though perhaps theoretically possible. For example, though it is conceivably possible, it is currently too complicated for humans to produce a baby entirely outside of the womb.<sup>5</sup> It should also be clarified that a futile action is not futile on the basis of its rarity or unusualness, such as the highly unlikely success of returning to health a mentally impaired drug addict with bacterial endocarditis (an infection of the heart). Rather, an action is futile because it will fail in its goals. These are often difficult distinctions to make as medical cases become increasingly complicated, and it will be useful to refer to them later if the need for clarification arises.

Since the beginning of the futility debate, doctors and ethicists have been dividing out the necessary conditions of futility in different ways. Mark Wicclair presents the idea that futility has three different senses: 1) Physiological futility, 2) Futility in relation to the patient's goals, and 3) Futility in relation to standards of professional integrity.<sup>6</sup> Physiological futility is the aspect of futility that asserts that certain medical interventions will not achieve their medical goals. Under this sense of futility, an action such as tube-feeding is futile if it will not succeed in providing sustaining nutrition. In this type of case, those with the greatest clinical expertise (doctors) will be the ones most likely to know the effects of a medical intervention, and whether or not that intervention will achieve the desired medical outcome.<sup>7</sup>

Several concerns arise when considering the idea of physiological futility. First, though doctors may understand whether the outcome will be successful, determining whether the outcome is an appropriate objective in the first place requires value judgments that go beyond the scope of their position. A doctor could consider that surgery X will not prevent further illness nor reduce pain and so is medically futile, while the patient may have other objectives in mind and so desire the surgery. Some types of cosmetic surgery may raise this objection, for example. Secondly, doctors may decide that a treatment is medically futile based on their expertise in relation to a standard of reasonableness, such as reasonable past success of that treatment. Again, a value judgment is required when deciding what constitutes a "reasonable" chance of success. Additionally, certain treatments cause benefits and negative effects simultaneously, and it is difficult to create a guide for handling these borderline cases.

The second sense in which medical futility is categorized by Wicclair is the idea that a treatment is futile if it will not achieve the goals of the patient.<sup>8</sup> While physicians can help the patient clarify his or her goals, perhaps through an explanation of physiological processes, they cannot choose which goals a patient should hold. When a doctor understands the goals of the patient, he or she can present the patient with the best possible options for continuing care. Does the patient wish to undergo a painful procedure with a low likelihood of success, or is the goal of the patient to have a potentially shorter, but less painful life? The patient must be asked if the treatment is, in their opinion, "worth the effort."

There are two major problems with this aspect of futility. First, patients and/or their surrogates may disagree with the doctor's opinion regarding the probability of achieving their goal through the treatment in discussion. The patient may feel they are healthy and of a strong mind and so will "beat the odds."

Secondly, even if the doctor and patient agree on the probability of the treatment being a success, they may disagree on whether that percentage is worth the risk. Patients often desire treatments despite their poor odds. From personal experience, I have found that when a patient is faced with doing nothing or doing something that has a low probability of success, if the treatment is bearable they will generally desire to give it a try. This objection returns us to one of the objections to physiological futility;

namely, that deciding what can be categorized as a “reasonable” probability, success, or outcome is a personal value judgment.

Wicclair’s third division of medical futility, futility in relation to standards of professional integrity, addresses the idea that a treatment is futile if there is no reasonable chance it will achieve any goals that are consistent with the rules of professional integrity. Though I find this measurement of “professional integrity” more ambiguous and difficult to explain than the first two divisions of futility, Wicclair is trying to get at the idea that there are proper goals of medicine and appropriate uses of certain medical interventions.

Physicians must maintain the integrity of their discipline by using treatments sensibly. These standards prevent doctors from providing services that are contrary to the standards of other physicians. A doctor could argue that providing CPR for a patient with heart failure is futile because the patient has a less than 1 percent chance of surviving long enough to leave the hospital. While the patient may request CPR in case of cardiopulmonary arrest, the doctor may claim that providing CPR is a misuse of the treatment, and that providing that treatment would violate the doctor’s professional integrity. In cases where professional integrity indicates a treatment may be futile, what specific aspect of integrity is being cited? Is the doctor using his or her own personal standards regarding CPR or widely accepted standards? These questions raise, once again, the same problem of relativism that the other two aspects of futility face. Wicclair argues that futility judgments using this third sense are only justified if they are legitimate standards within the medical profession.

While certain standards can be discussed in advance, a large portion of the discussions in cases of medical futility is a discussion of quality of life and is different for each individual patient and their family. If we accept this qualitative component to the discussion of medical futility, which I do accept, then “why should the patient not always decide whether the quality achieved is satisfactory or not? Why should qualitatively “futile” results not be offered to the patient as an option?”<sup>9</sup> This is a contentious subject in the medical futility literature; doctors declaring a treatment futile has been construed as medical professionals asserting their power over the autonomy of the patient.

This perspective, that the autonomy of the physician supercedes the autonomy of the patient, is based on the idea that doctors and patients are involved in a continuing power-struggle for control, with doctors having the upper hand. Declaring a treatment futile is not a “trump card” in this relationship, but rather a necessary part of the physician’s duty of beneficence. Futility must not be declared arbitrarily, but rather established within the medical discipline to preserve professional standards.<sup>10</sup> When everything has been done and a patient is dying, through further treatment may be declared futile, continuing palliative care is never futile.<sup>11</sup>

Using Wicclair’s divisions of futility as a guideline, I propose this working definition of medical futility: *A treatment should be considered futile if it will not be beneficial to the physiological or psychological health of the patient.*

This definition states that a treatment is futile if it will not solve the medical problem, and also incorporates the idea that a treatment may not be futile if the treatment is important the patient’s goals. Acknowledging that it is possible for an individual to have goals that are non-health promoting, the idea of treatment promoting a patient’s “psychological health” is based on the rational that a mentally healthy and competent adult will not generally desire treatment that is deleterious to their health. The patient may desire treatment that will prolong their life at a quality that

may not be seen as particularly desirable, but most patients are motivated to continue further treatment to prolong their healthy life, not prolong a life in PVS, for example. This assumption may be challenged, though the risks of defining futility solely in terms of a patient's goals and desires raise many additional ethical challenges, some of which I have raised in this paper.

My definition excludes Wicclair's notion of professional integrity because it is even more arbitrary than what may arguably be seen as a definition that is too vague to be useful. If the medical team could gain a better understanding of the patient and/or their family's reasoning, perhaps the lines of communication would be more productive. A mutually acceptable decision might be easier to reach; patients and families would feel less powerless to get what they need, and the doctors would feel less conflicted about providing care that they feel is futile or unethical.

Patients and families who must make treatment decisions when the case is deemed futile – meaning that the treatment will not benefit the patient either physiologically or psychologically – have a difficult task and many emotions to balance. As medicine continues to advance, and patients are revived from progressively more dire conditions, it will become increasingly important to understand the concepts central to the medical futility discussion.

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- 3 Mark R. Wicclair, "Medical Futility: A Conceptual and Ethical Analysis," in Thomas A. Mappes and David DeGrazia, *Biomedical Ethics*, 4th Ed. (New York, USA: McGraw-Hill, Inc., 1996), 346.
- 4 Lawrence J. Schneiderman, Nancy S. Jecker, and Albert R. Jonsen, "Medical Futility: Its Meaning and Ethical Implications," *Annals of Internal Medicine*, vol. 112 (June 1990), 950.
- 5 Lawrence J. Schneiderman, Nancy S. Jecker, and Albert R. Jonsen, "Medical Futility: Its Meaning and Ethical Implications," *Annals of Internal Medicine*, vol. 112 (June 1990), 950.
- 6 Mark R. Wicclair, "Medical Futility: A Conceptual and Ethical Analysis," in *Biomedical Ethics*, 4th Ed., 346.
- 7 *Ibid.*, 347.
- 8 *Ibid.*, 348.
- 9 Lawrence J. Schneiderman, Nancy S. Jecker, and Albert R. Jonsen, "Medical Futility: Its Meaning and Ethical Implications," 952.
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- 11 Dianne Bartels. Minnesota Center for Bioethics, MN. Conversation, 2004.

## Futile Treatment Examination

Select the *best* answer to each of the following items. Mark your responses on the Answer form.

1. FOR the past \_\_\_\_\_, there has been a debate raging within the medical, ethical, and legal communities focusing on the issue of medical futility. Despite the emergence of medical futility as a dominant topic of discussion, especially as it applies to end-of-life care, the concept is not new.

- a. year
- b. few years
- c. decade
- d. None of the above

2. What has fueled the fires of this multi-faceted debate is the patient rights movement and the perception that the right of self-determination extends not only to the refusal of medical treatments but to demands for overtreatment.

- a. True
- b. False

3. The medical specialties of Pediatrics and Neonatology further complicate the issue of medical futility because despite the dramatic technological advances in these areas, diagnostic and prognostic certainty for many medical conditions remains illusive. As a result, surrogates have to decide whether children with \_\_\_\_\_ should be treated aggressively if at all.

- a. various diseases
- b. congenital anomalies
- c. genetic defects
- d. All of the above

4. The death of a child, especially when it results from withholding or withdrawing medical treatment, can be viewed as \_\_\_\_\_. The mere mention of distributive justice and scarce medical resources only compounds the complexity of medical futility decisions, because many Americans view this as placing a price tag on human life.

- a. unjust
- b. premature
- c. cruel
- d. All of the above

5. Futility means "inadequacy to produce a result or bring about a required end; ineffectiveness". Medically, the concept of "futility," according to the American Medical Association, \_\_\_\_\_. Essentially, futility is a subjective judgment, but one that is realistically indispensable.

- a. the meaning varies from case to case
- b. cannot be meaningfully defined

- c. means there is no suitable treatment available
- d. None of the above

6. Today, various medical and bioethical organizations have risen to the challenge of affirming the limits of medicine by agreeing with this long-standing historical view that there is no moral obligation to provide futile treatments. However, despite this apparent consensus, the determination of when such medical treatments are clearly futile continues to plague both medical and ethical professionals.

- a. True
- b. False

7. To address this concern, physician-bioethicist Edmund Pellegrino has established a combination of subjective and objective criteria which will allow decision-makers in consultation with physicians to make medical decisions about when certain treatments are no longer beneficial. His approach, which is historically based, strikes a balance between three criteria: \_\_\_\_\_.

- a. effectiveness
- b. benefits
- c. burdens
- d. All of the above

8. Patients have the right of self-determination to control their own medical treatment, but this does not give patients the absolute right to demand any medical treatment. Physicians have the duty to practice medicine responsibly, that is, they are called to follow professional \_\_\_\_\_ as guides to their judgments on the appropriateness of medical interventions for their patients.

- a. norms
- b. standards
- c. values
- d. All of the above

9. In determining whether a particular treatment is beneficial to the patient it is important to distinguish between quantitative futility and qualitative futility. Quantitative futility is an objective assessment of a particular medical treatment that should be made by the physician.

- a. True
- b. False

10. Justice recognizes that all people should be treated fairly and be given what they are due. The issue of medical futility focuses specifically on distributive justice, that is, the \_\_\_\_\_ distribution of

medical resources in society. In determining if a particular medical treatment is futile, one cannot remove this decision from the realm of social justice.

- a. fair
- b. equitable
- c. appropriate
- d. All of the above

11. The mention of cost factors and scarce resources in discerning medical treatments brings the criticism that one is "putting a price tag on human life," even though, by not having some kind of universal health care coverage, the United States puts a price tag on human life in a massive way every day.

- a. True
- b. False

12. Critics also will argue that incorporating distributive justice into the medical futility debate is just a devious disguise for medical rationing. This only confuses the issue. Futility judgments and allocation decisions are very different from rationing. Futility refers to specific treatments and outcome relationships with a specific patient. Rationing refers to withholding of efficacious treatments in the general population on a cost basis because of competing needs

- a. True
- b. False

13. The medical futility debate comes down to a conflict between patient autonomy versus physician beneficence and distributive justice. In seeking a balance between the values and goals of medicine and the values and goals of the patient, individual autonomy cannot be so inflated in importance as to destroy the principle of beneficence and overlook the equitable distribution of medical resources in society.

- a. True
- b. False

14. The futility debate is complex because it incorporates not only medical components, but also \_\_\_\_\_ components. Physicians are not medically, ethically, or legally obliged to offer a patient medical treatments which they believe to be nonbeneficial or inappropriate.

- a. social
- b. ethical
- c. legal
- d. All of the above

15. Until the concept of futility is clarified and ethical policies are formulated, physicians will continue to comply with patient's/surrogate's requests for medically inappropriate treatments because the fear of \_\_\_\_\_ hangs over their heads like the sword of Damocles.

- a. medical errors
- b. malpractice
- c. medical boards
- d. None of the above