

FUTILITY, AUTONOMY, AND INFORMED CONSENT

Informed consent is the legal and moral institution that enshrines patient autonomy as the crucial determinant with respect to treatment options, especially those which could cause more harm than good or those which could have irreversible or fatal consequences. When the benefits of treatment are likely to carry serious burdens, healthcare professionals are especially careful to ensure that patients understand and agree to assume those burdens.

Since futility renders treatment burdensome and patients are likely to refuse burdensome treatment, it is essential that healthcare professionals disclose to patients the futility of a proposed treatment. But if clinicians deem a treatment medically futile, is it appropriate to offer it as a genuine option? Do healthcare professionals violate informed consent if they do not offer patients an opportunity to decline futile treatments?

To answer these questions, we must first answer the following questions related to futile care and informed consent:

- Are healthcare providers obligated to provide a medically futile treatment when patients request that it be provided?
- To what extent are care givers morally obligated to inform patients of medically futile treatment options?
- What is healthcare providers' obligation to comply with patients' wishes when those wishes

Physicians Have No Obligation To Offer Futile Treatments

BY JANE MARY
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would render medical care futile?

- What is healthcare providers' obligation to provide treatment for noncompliant patients? Consider this hypothetical case:

During his second lobectomy for cancer, a 78-year-old man has a series of strokes that

Summary If clinicians deem a treatment medically futile, is it appropriate to mention such a treatment to patients? Do healthcare professionals violate informed consent if they do not offer patients an opportunity to decline futile treatments?

The notion of futility involves an assessment of patient best interest—both short-term and long-term therapeutic benefit for a patient and the community in which he or she intends to survive and flourish. Although survival interests may be construed as long term, a treatment that offers survival without any promise of flourishing is not the goal of medicine and is futile. Flourishing requires some cognitive and affective function.

The goal of informed consent practices is to ensure that patients accept the benefits of treatment with cognizance of the burdens and risks. Given the impact of illness on the emotional and psychological states of patients and their families and their resultant vulnerability, the omission of futile options from treatment plans is logical and exemplifies the best of paternalistic behavior.

The claim that requests for futile treatment must be honored is based on a perverse understanding of patient autonomy. Rational medicine demands that patients' requests be reasonable from a clinical perspective, as well as from a subjective one. The practice of informed consent can be implemented as a balance between these two interests.



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leave him with irreversible brain damage. Although the surgery was successful from a pulmonary perspective, the man never regains consciousness and develops abdominal bleeding several weeks later. The bleeding is corrected through surgery but recurs several months later. Laboratory work indicates the patient will probably go into renal failure within three days. His physicians agree he is headed toward multi-system failure. The physicians prepare the man's family for this and ask them to agree to a do-not-resuscitate order. The physicians decide that if the patient's kidneys fail, they will not offer dialysis as a treatment option because such treatment would be futile.

Have this man's physicians violated his informed consent by not offering dialysis as a treatment option? Once the patient's physicians have agreed that kidney dialysis would be futile, should the patient or his surrogates have the opportunity to accept or decline dialysis as a treatment option?

OBLIGATION TO PROVIDE MEDICALLY FUTILE TREATMENT

The notion of futility involves an assessment of patient best interest—both short-term and long-term therapeutic benefit for a patient and the community in which he or she intends to survive and flourish.¹ Survival interests pertain to those goods required to sustain physical life; flourishing interests involve the pursuit of a meaningful and purposeful existence. Short-term interests concern the immediate consequences of a specific act (e.g., the prospect for stopping the abdominal bleeding in the case of the lobectomy patient); long-term interests concern the elimination or management of a disease or condition that affects a person's ability

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to flourish (i.e., to pursue that which is of ultimate value). In the case of the lobectomy patient, the long-term interest would be his return to the pursuit of his life's purpose or plan.

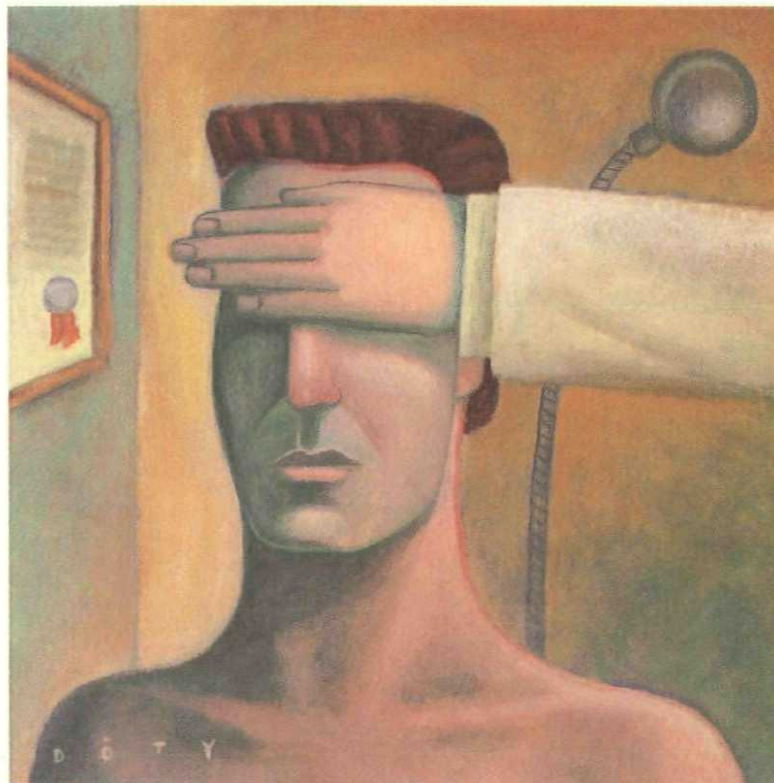
The distinction I make between long-term and short-term interests is consonant with the distinction made between the effect of a medical treatment and the benefit of that treatment.² Michael Coogan ties this conceptual differentiation to the notion of patient best interest: "A whole person can have best interests. Separate physiological systems cannot."³ Or as Robert M. Veatch and Carol Mason Spicer put it:

The real problem is not with care that clinicians believe has literally no effect. The real problem is with care that has an effect, but that clinicians believe has no benefit. That is not a judgment based on medical science. It is grounded in beliefs and values about which people inevitably disagree. In such situations, clinicians' judgment cannot be decisive.⁴

The *effect* of a treatment is its impact on a disease, an organ, a pathological condition, the mind, or a body part. This definition of effect is conceptually aligned with my use of short-term benefit because it refers to the immediate physiological result of a proposed treatment.

The *benefit* of a treatment is the impact of that treatment on the whole person (i.e., the existential human person as a composite of his or her value system, beliefs, goals, and ability to realize those)—in short, the impact on a patient's life plan, or that person's long-term benefit. Although survival interests may be construed as long term, a treatment that offers survival without any promise of flourishing is not the goal of medicine, and is futile.

The goal of medicine is to restore patients to



Curt Doty



a state in which they can pursue a life plan. Pursuing a life plan involves patients' ability to set goals and the means to achieve them, modify those means, and adopt new goals if necessary. The medical profession thus encompasses healing, as well as adjustment to new life-styles. Thus the preservation of mere physiological life (e.g., patients in persistent vegetative states [PVSs]) is contrary to the goal of medicine.

Other recent discussions refer to the goal of medical treatment as virtually synonymous with the above usage of benefit or long-term interest.⁵ The goal of a medical treatment may be understood differently by patients and families, physicians, nurses, healthcare institutions, or communities. In the case of Helga Wanglie, for example, her husband's goal was to prolong physical life in the hopes of a miraculous recovery, whereas the medical staff's goal was to restore her to a meaningful life. When medical staff agreed that their goal could not be reached, they decided the use of a ventilator was futile and sought to discontinue its use. Mr. Wanglie, on the other hand, saw

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the ventilator as useful to the accomplishment of his goal and thus as beneficial treatment for his wife. As David H. Johnson observes, "One of the principal reasons that futility is difficult to define is that a treatment can only be futile in relation to a specific goal."⁶

These attempts at conceptual clarification reveal the real tension between the short-term benefits a specific medical treatment can offer a patient even if it offers no long-term benefit. This tension is at the foundation of many personal crises for patients, families, and medical staff in intensive care units (ICUs) and long-term care facilities as we continue to offer treatments that have real effect—for example, reversal of a hypotensive episode or resuscitation—but no real benefit for patients who linger in twilight or PVS with no hope of a return to a meaningful life.

It is important to stress that flourishing requires some cognitive and affective function. Although determinations of the meaning and value of life are subjective, the evaluation of the possibility of pursuing any meaningful life is objective.

PHYSICIANS' VIEWS OF FUTILE TREATMENTS

Many physicians frequently face decisions about withholding or withdrawing treatment. Do they believe medical treatment can be effective but not beneficial? What factors do they find most important when determining futility? Are there non-medical benefits that justify offering treatment having no medical benefit? I interviewed several physicians who frequently deal with treatment abatement decisions to learn their answers to these questions.

BENEFICIAL BUT INEFFECTIVE TREATMENT

Medical treatment can be beneficial but ineffective, noted John Collins Harvey, MD, PhD, professor of medicine, emeritus, Center for the Advanced Study of Ethics, Georgetown University, Washington, DC.

For example, trichinosis is a disease that causes patients pain and discomfort, a disease that must run its course because it has no cure. Steroids are beneficial because patients become symptom free; however, steroids are ineffec-

tive because they do not affect the pathological process.

"Treatment would be effective in the sense that it would knock out the disease process but would have no influence on the reaction of the patient from a physical standpoint, which is what is the beneficial part of the treatment," said Harvey.

In the case of persons in a persistent vegetative state (PVS), artificial nutrition is "effective in maintaining pure biological life," acknowledged Harvey. But artificial nutrition is "not effective in the sense that it's going to correct a pathological process," he remarked. Such treatment is "beneficial if your purpose is to support vitalism, which I don't do," stated Harvey. He added that repairing a hernia in a PVS patient "would be effective treatment but would not be of any benefit to that individual as a person because he or she does not have the biological substrate to express personhood."

Harvey believes that physicians can view treatment as effective or ineffec-

tive, not as futile. "I cannot decide what is futile for a patient," he said. "It is the patient who must make that judgment of whether he or she wishes to receive a treatment in accordance with his or her own values. 'Quality of life' is subjective; it's perfectly appropriate for a patient to use the term in evaluating for himself or herself the burdens and benefits of a treatment, but not for the physician to make that judgment," asserted Harvey. (For an in-depth discussion on euthanasia and physician-assisted suicide, see Harvey and Edmund D. Pellegrino's article in this issue, pp. 36-39.)

INEFFECTIVE AND NONBENEFICIAL EQUALS FUTILE

Sometimes an effective treatment is more harmful to the patient than the disease, noted Susan Hill, MD, Atlanta Nephrology Associates, and chairperson of the Ethics Resource Committee, Saint Joseph's Hospital, Inc., Atlanta. Some treatments "work for a specific indication" but do not improve the patient's

Clinicians can determine whether any brain function is or will be present. If clinicians determine that cognitive and affective function are lost, then a patient cannot pursue a meaningful life regardless of what a meaningful life can be said to be.

We should take due care to prevent clinicians from assuming or from being assigned the "moral or religious authority" that would permit them to determine whether life is worth living. Nonetheless, if we reject vitalism, we can affirm that when there is no hope at all of pursuing a meaningful life, clinicians can rightly conclude that effective medical treatment will not benefit a patient. Hence, clinicians might deem an effective procedure to be futile for a PVS patient. If, however, there is some hope, even slim, that the patient will recover some cognitive and affective function, then the patient or designated decision maker should be the sole determinant of whether the prospects for flourishing justify any burdens that might inhere.

Individual Interests Versus Communities' Interests
Individual interests, both short term and long

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term, as well as survival and flourishing interests, are met within the context of a community. The survival of a group may, at times, require that individual needs be sacrificed for the sake of the greater good. This arrangement is understood as a requirement for membership in the group. However, individual interests are sacrificed only when they are impossible to meet, or when meeting the needs of one will jeopardize the needs of the many. (Such evaluations must be free of any prejudice or injustice.) But if an individual's request for treatment is denied after a cost-benefit analysis shows that it is not in the best interests of society, it still may not be appropriate to deem that treatment medically futile for that specific patient. That is to say, cost-benefit analyses should not be the sole criteria or motivating force in the assessment that a particular treatment is futile for any individual patient. As Nancy S. Jecker and Lawrence J. Schneiderman have written:

Whereas the goal of cost containment is to reduce overall expenditures, the point of

overall health. Hill sees treatment as beneficial when it allows a patient to return to a level of life-style he or she finds satisfactory, with acceptable interactions with others even if some limitations remain.

Hill believes treatments that provide nonmedical benefits are worthwhile. She noted that cancer patients often find it difficult to accept that no treatment will cure them. When this occurs, Hill explained, trying a treatment that at the very least may help cancer patients feel a little better "leaves them with a lot of hope and belief that they are getting some help. . . . That's worth a try." Hill added, "True futility is when not only is a treatment ineffective, it's not beneficial either."

Only patients, their families, and their physicians can determine the level of a treatment's futility. "It's a very personal thing between a physician, the patient, and the family," stated Hill. She explained that everyone views life and treatment differently. Some people want to try every option, Hill noted.

PATIENTS IN PVS

If possible, physicians should discuss with patients and families what treatments would be offered if the patient goes into a PVS before the acute event occurs. "If I have a patient who is in a PVS, I would want to have an understanding that even if we had a treatable illness which might hasten the demise, we would not treat it because the treatment would not be of any benefit to the patient," stated pulmonologist Paul Scheinberg, MD, of Atlanta.

Scheinberg added, however, that if the agreement was to be conservative (e.g., only providing nutrition and hydration), but in the course of putting in a central line for nutrition and hydration the patient develops a pneumothorax, physicians "are now obligated to follow through and treat that injury, whereas if a patient had developed a spontaneous pneumothorax, we might not treat it."

Futility is determined by a patient's neurological status, Scheinberg stated. When asked whether he would operate

to remove a bowel obstruction in a PVS patient, Scheinberg responded, "If there were no mentation, I would not intervene, except to be sure that we were relieving pain, even visceral pain."

If the family insisted on surgery for a bowel obstruction, Scheinberg would tell the family that he would "find it difficult to find a surgeon who would undertake therapy that would probably be proved professionally to be inappropriate." Instead, Scheinberg said he would advise the family to act "not in their own interest but in the interest of the patient. I would remind them of the patient's state and that their job is not to worry about betraying the patient" but rather to ensure they are acting in the patient's interest.

Scheinberg added, "In the case of a patient with severe neurological deficit and no hope of recovery of mentation, provision of therapies such as corrective surgery are futile, even though they are effective, and the provision of such would be an abuse of the patient and of society's resources."



identifying interventions as futile is to determine that they are not beneficial to the patient. Thus futile interventions remain futile even if they are relatively inexpensive so that omitting them does not significantly reduce health expenditures.⁸

Short-Term Versus Long-Term Interests The determination that a treatment option is futile may result as a consequence of measuring a patient's short-term interests against long-term interests and measuring the survival against the flourishing interests. In the case of the lobectomy patient with abdominal bleeding, a consideration of all these interests may result in an assessment that dialysis would be futile, since it would not be of long-term therapeutic benefit to the patient, even though it might manage his renal failure on a short-term basis. Furthermore, a short-term success with the renal problem would not improve his prospects for flourishing. Hence, in spite of the short-term success of the specific treatment proposed (i.e., the dialysis), that treatment can be assessed as futile with respect to the patient's long-term flourishing interests.

Given these considerations, we may conclude that any proposed treatment can be deemed *medically futile* if it offers no long-term benefit or real hope of realizing the goal of medicine (i.e., to restore a patient to a state in which he or she can pursue a life plan) even though that treatment may offer some short-term benefit.

Nonmedical Benefits Given the scarcity of medical resources, including equipment, personnel, organs, facilities, and funding, it seems difficult indeed to justify treatment when it is futile. Some persons argue, however, that it may be necessary to "buy time" for some dying patients and their families so they may come to terms with the terminal illness. Although futile, treatment is sometimes rendered in these cases to provide time for emotional, spiritual, and financial preparation. William Knaus says:

Sometimes, for example, there are patients and patients' families who, even though we do not think we are providing them any benefit, want to use the experience of the ICU as a ritual towards death. Although the ritualistic use can be viewed as a misuse, it still can be of value and should not be intruded upon.⁹

Also, some clinically futile treatments (e.g., chemotherapy) may be seen as palliative, especial-

ly if they stave off psychological harms like hopelessness or feelings of abandonment.

The value of nonmedical benefits and their relation to utility are important. Healthcare professionals' dedication to providing care for the whole person may incline them to provide treatment that is clinically futile in order to meet these other needs. If these benefits greatly contribute to patients' and families' quality of life, they may not be perceived as futile even though they offer no therapeutic benefit. In these cases the non-medical goods may justify the use of futile treatments. But this would require a rigorous benefit-burden assessment and might properly be seen as an act of kindness rather than the performance of a duty. Treatments that provide nonmedical benefits may be withheld if the harm they cause a community exceeds the benefit they provide a patient.

A recent draft of an institutional policy concerning physicians' right to refuse to provide futile treatment puts the matter as follows:

The goal of health care is to improve patients' health, not to relieve families' grief. The improvement of health implies that the patient has some capacity to experience that improvement.

Society has no necessary interest in the symbolic use of health care.¹⁰

If a treatment is perceived as futile, in both the medical and nonmedical sense, there is no good reason for providing it. Rational medicine, as defined by Edmund D. Pellegrino and David C. Thomasma, is medicine practiced with "diagnostic elegance (just the right degree of economy of means in diagnosis) and therapeutic parsimony (just those means that are demonstrably beneficial and effective)."¹¹

If a treatment offers no benefit, then offering it would be irrational, and the request for it could be made only by one who did not understand its futility. Healthcare professionals' moral obligation would be to explain a treatment's futility and the irrationality of its use. Even if that educative effort failed, healthcare professionals would not be obligated to provide treatment. In fact, they may be obligated to refuse such requests because compliance would be equivalent to practicing irrational or "bad" medicine and would thus be unethical. If a treatment offered only nonmedical benefit, but at an unreasonable cost to society, healthcare professionals would be justified in refusing to provide it.

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Withholding Options Futility is not limited to end-of-life decisions; however, it is certainly more prevalent there. For instance, further skin grafts on the foot of a diabetic patient might be futile, and amputation might be indicated; root canal on a tooth with a fractured root might be futile, and extraction might be indicated. The essential aspect of the concept of futility, in these and in end-of-life cases, is that specific courses of treatment are no longer effective or beneficial and must be abandoned.

OBLIGATION TO INFORM ABOUT FUTILE TREATMENTS

The goal of informed consent practices is to ensure that patients accept the benefits of treatment with cognizance of the burdens and risks. This goal is not negated by the omission of futile options from treatment plans. But one might ask what harm would come from mentioning futile treatments and describing them as such.

The main concern in a clinical setting is that patients or their families, clinging to desperate and false hopes for recovery, might interpret the discussion of a specific treatment as an indication that it offers a genuine possibility for therapeutic benefit. A related concern is that a treatment likely to offer a short-term success will be interpreted as a long-term therapeutic benefit. A third possibility is that families may acknowledge the futility of treatment but insist that it be provided anyway as a gesture of their love for the patient.

Given the impact of illness on the emotional and psychological states of patients and their families and their resultant vulnerability, the omission of futile options from treatment plans is logical and exemplifies the best of paternalistic behavior.

Balancing Subjective and Objective Interests Clinicians must often describe treatment options that offer benefits to patients only at the expense of some other good (e.g., financial cost, comfort, mobility, unrestrained activity). Sometimes the prediction of these harms is a calculation of probabilities, whereas other times it is a virtual certainty. Some physicians believe they need not inform patients of statistically low or extremely rare occurrences when describing treatment options. But when there is significant evidence of negative results or side effects that are irreversible or long lasting, patients must determine whether the benefits are worth the risks.

Consider this case:

A 55-year-old woman is diagnosed with cancer of the right breast. The surgeon suggests a radical bilateral mastectomy,

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with removal of the left breast as a prophylactic measure. The patient refuses the removal of the left breast and insists on immediate reconstructive surgery of the right breast. She explains that she fears losing her husband's affection. The physician responds that she is being unreasonable and her fears are exaggerated.

The long-term and irreversible risks of the proposed treatment are, in this case, mostly subjective. There is the possibility of cancer occurring in the left breast, and even possible complications of reconstructive surgery. A candid disclosure of the risks involved in the treatment requested by the patient is appropriate, as is a genuine consideration of the risks the patient perceives in the surgeon's proposal. But the patient must decide which risk scenario is acceptable to her, so long as her desires are not unreasonable (in terms of their effect on others or society).

OBLIGATION TO COMPLY WITH WISHES THAT MAKE TREATMENT FUTILE

What if a patient's treatment request would render nonfutile treatment futile? Consider this case:

A man is admitted to a hospital for cardiac bypass surgery. He indicates that he does not want a ventilator. He has a cardiac arrest. Do healthcare providers institute cardiopulmonary resuscitation (CPR) without the ventilator?

It is likely that this patient did not understand his request. He probably intended to request that he not be kept alive on a ventilator if he were in a state from which there was no hope for recovery of cognitive and affective function. Even so, are healthcare providers obligated to comply with his request if it is unreasonable?

Healthcare professionals could address this case through patient education. But the larger issue is whether patients' requests should be honored no matter what they are, especially when they directly interfere with responsible and effective medical care.

The case can be made that healthcare providers are obligated to *deny* patients' requests for treatment if those requests render treatment useless by ensuring or increasing the probability of failure. When patients request futile treatments (such as CPR without chest compressions or intubation), healthcare providers should first inquire why they are requesting these limitations. Providers may



find that patients simply *intend* something other than what they request. If, on the other hand, patients fully understand their request (e.g., the refusal of blood products), healthcare professionals must ensure that they also understand the risks they incur. If providers believe the request so jeopardizes the procedure that treatment is rendered futile, they may refuse to comply with the request, even if that refusal is perceived as a violation of patient autonomy.

OBLIGATION TO TREAT NONCOMPLIANT PATIENTS

When a patient does not comply with a treatment, noncompliance may render the treatment futile. The issue of noncompliance is related to the issue of responsibility, a key factor in assigning moral praise and blame.¹² The assessment of responsibility requires that a thorough account be given of patients' ability and freedom to comply, specifically of their ability to understand instructions, their level of literacy, their financial ability to comply (e.g., to purchase medications and travel to offices and clinics), any cultural obstacles to compliance (e.g., ethnic diets, peer pressure to participate in social rituals that conflict with treatment requirements), and the freedom from compulsion to engage in noncompliant behavior (e.g., substance addiction). Interventions in the form of education and substance abuse rehabilitation programs may fail because patients simply cannot overcome entrenched social and economic barriers to compliance.

Patients who suffer from chronic illnesses may go through periods of noncompliance simply because they are fed up with years of medications and therapies. This is not to say that patients should be absolved from responsibility for their own health. It is, rather, a plea for compassion when tempted to refuse patients because their noncompliance renders treatment futile. Refusal to treat in these cases is legitimate only when healthcare professionals have sincerely tried to understand and address the reasons for noncompliance.

Futility, whether the result of noncompliance or an assessment based on short-term and long-term benefits, is best understood as a clinical concept (i.e., as the appropriate designation for treatment that can offer no hope of long-term therapeutic benefit, even if short-term successes are possible). Patient self-determination, although an important value, may be rightly limited when the treatment in question is futile.

AUTONOMY

Recent discussions on the inadequacy of autonomy or self-determination as the prevailing prin-

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ciple in biomedical ethics have focused on general problems with the concept (i.e., its origin, its relation to rights discourse, the impairment of autonomy by illness).¹³ The claim that requests for futile treatment must be honored is based on a perverse understanding of patient autonomy.

Benefits and Burdens In a medical context, patient autonomy is rightly restricted to the belief that individual patients (or their surrogates) are the only ones who should decide whether the ratio of benefits to burdens of proposed treatment options is acceptable.

Consider the following case:

A 68-year-old man with emphysema consults an orthopedic surgeon for relief from limited mobility and constant, severe pain in a shoulder injured in three separate events. The surgeon offers him a complete shoulder replacement with the following prospects: a slight increase in range of motion and a fragile shoulder with less strength than before. He must take care not to damage the replacement because repair is virtually impossible. The only benefit offered is the complete removal of all pain.

In this case only the patient can assess the relative value of the proposed treatment's benefits and burdens. One person may choose the surgery, while another may decline. Only this patient, with his individual tolerance of pain, history of surgeries, specific chronic diseases, and other factors, can determine whether the benefits justify the risks, especially the risks presented by his age and existing chronic pulmonary condition.

Reasonable Treatment Autonomy does not give patients license to demand unreasonable treatment. Healthcare professionals must take care that what they deem unreasonable is not prejudiced by their subjective values. For instance, it is not unreasonable for a dying mother to refuse to consent to a do-not-resuscitate order so that she can remain alive to see her daughter graduate high school, even though her prolonged life is riddled with pain. Nor is it unreasonable for persons to decline blood products because of their religious beliefs.

Requests are unreasonable if they render treatment futile, as described earlier, or if they result in the practice of irrational medicine. Requests aimed at fulfilling lifelong goals, resolving family

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resources and treatment of staff).

Religious-Transcendental Values Religious-transcendental values ground us in our identity and give purpose to our care of the sick (e.g., Christlike compassion, commitment to Gospel values, special reverence for the dying and the unborn, commitment to patients' spiritual needs, sacramental presence). Articulation of these values is essential, for they publicly proclaim that care of the sick is not merely a work of charity that we perform from nine to five. Rather, care of the sick and the poor is a constitutive element of the Gospel, and participation in this sacred ministry affords each person an opportunity to work out his or her own salvation. To delete this essential component of Catholic healthcare because it makes others uncomfortable or because it is not politically correct is to deny the essence of our identity and to reject our founders' intent.

MAINTAINING A MINISTRY MODEL OF CARE

We believe that the values articulated in a Catholic healthcare facility's mission statement should contain components from each of the four value strata. If the values in the facility's mission statement merely reflect the first three levels, then our institutions may provide high-quality healthcare. However, they may become so homogenized that they will not only lose their identity but will become additional victims of the profound sociological forces that are moving Catholic healthcare from a ministry to an industry model of care.

Two thousand years ago, Jesus asked Peter a question of identity: "Who do you say that I am?" Likewise, his followers are confronted with questions of identity: What makes a Catholic hospital Catholic? One can only point to the vision from which all mission statements must flow—the vision of Jesus, which challenges individuals and institutions to adopt values that are countercultural and which, if lived, will give rise to a clear sense of identity and purpose. Being politically correct is in vogue these days, but being countercultural is the essence of the Gospel call. □

situations, reconciling oneself to one's enemies, or making peace with God are not unreasonable. It might well be, however, that such requests need not be honored because they conflict with other goods.

This narrow interpretation of autonomy within the medical context acknowledges that reasonableness and subjectivity are to some degree related. What is reasonable for one patient in part depends on that person's subjective values. But rational medicine demands that patients' requests be reasonable from a clinical perspective, as well as from a subjective one. The practice of informed consent can be implemented as a balance between these two interests.

PROVIDERS AND PATIENTS ARE RESPONSIBLE

If we understand "autonomy" as self-determination, and "informed consent" as the practice that protects autonomy in a medical context, informed consent applies narrowly to the balance of the subjective interests of patients and the practice of rational medicine. Informed consent refers to the supremacy of patient desires and requests when the benefits of a proposed treatment are balanced against the risks.

Clinicians must take due account of the nonmedical benefits of certain treatments and credit those in descriptions of benefit-burden ratios. Both patients and providers, however, must acknowledge that benefit-burden ratios may include the good of families and communities, as well as the subjective interests of the patient. This means that patient desires and requests cannot obligate healthcare providers to comply with requests for futile treatment or with requests that would render treatments futile, and that treatment which is futile need not be offered to patients for consideration under the practice of informed consent. □

NOTES

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7. I am grateful to Robert M. Veatch, PhD, director and professor of ethics, Kennedy Institute of Ethics, Georgetown University, Washington, DC, for his comments on this article, particularly this section.
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11. Edmund D. Pellegrino and David D. Thomasma, "The Physician as Gatekeeper," in Thomas A. Mappes and Jane S. Zembaty, editors, *Biomedical Ethics*, 3d ed., McGraw-Hill, New York City, 1991, pp. 122-128.
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13. Jane Mary Trau, "Relational Ethics in a Medical Context," *Cambridge Quarterly of Healthcare Ethics* (in press).