

TIME FOR A FORMALIZED MEDICAL FUTILITY POLICY

Mercy Health System's Procedures Will Help Free Its Physicians from Legal Concerns

BY REV. PETER A. CLARK, SJ, PhD, & CATHERINE M. MIKUS, ESQ.



Fr. Clark is assistant professor of theology and holder of the John McShane Chair of Ethics, St. Joseph's University, Philadelphia, and also serves as bioethics consultant, Mercy-East Health System, in that city; Ms. Mikus is associate counsel for legal affairs, Mercy Health System, Conshohocken, PA.

For the past decade a debate has raged in the medical, ethical, and legal communities over *medical futility*. The concept is not new, especially as it applies to end-of-life care. Physicians since the time of Hippocrates have recognized some medical conditions as hopeless and have accordingly recommended no further treatment for the patients suffering them.¹ But what has fueled the fires of the recent debate is the patients' rights movement and the accompanying perception that the right of self-determination extends not only to the refusal of medical treatment but to demands for overtreatment as well.²

The patients' rights movement began as a reaction to the paternalism of physicians who unilaterally overtreat patients, prolonging their lives against their wishes or the wishes of surrogates or family members. This reaction resulted in a series of lawsuits, ranging from the Karen Quinlan case of 1975 to the Nancy Cruzan case of 1990, in which the courts ruled that patients (or their appropriate surrogates) had the right to refuse treatment even if this led to the patients' deaths.

In the 1990s, patients and surrogates began to demand treatments that their own physicians often believed were medically futile and thus an irresponsible stewardship of healthcare resources. In lawsuits ranging from the Helga Wanglie case of 1991 to the "Baby K" case of 1994, the courts have ruled in favor of the right of patients and surrogates to request certain medical treatments.³ What has made these cases especially problematic is an absence of professional or institutional policies concerning medical futility. Because of this lack, judges have found determining compliance or noncompliance to be difficult.⁴

Patients and surrogates argue that if they have the right to refuse certain medical treatments, they must also have the right to request them; in

either case, they say, they know what is in their best interest. Physicians, on the other hand, argue that such treatments are often both burdensome for the patient and medically inappropriate because—since they fail to achieve the desired physiological effect—they amount to a misallocation of resources. Many physicians believe that allowing such treatments compromises their professional integrity. Nevertheless, they often feel compelled to comply with the patient's or surrogate's wishes because they think that is what society wants.⁵

The ever-present fear of litigation has not only exacerbated this debate, it has also put the very foundation of the physician-patient relationship in jeopardy. When patients adopt the extreme autonomy position, they ignore the fact that objective, well-established, community-based "best interest" standards assume both a connectedness of the patient to family and physician and a communication process that allows surrogates to make decisions based on those standards.⁶ To address these concerns, society should try to avoid both physician-driven overtreatment and that driven by patients and surrogates, seeking a balance between patient/surrogate rights and physician/societal rights.⁷

Those working in the Catholic legal and ethical tradition might do this by taking a process-based approach on a case-by-case basis. The goal would be a medical futility policy that, securely rooted in the Catholic tradition of promoting and defending human dignity, protects the patient's right of self-determination, the physician's right of professional integrity, and society's concern for the just allocation of medical resources.

This article will:

- Examine the legal implications concerning the medical futility issue
- Show how three concerns—patient auto-

my, physician beneficence, and the just allocation of medical resources—affect the ethical determination of medical futility

- Suggest a medical futility policy that can be implemented in a Catholic acute care facility

LEGAL IMPLICATIONS

Because medical futility policies are relatively new in healthcare, there is tremendous uncertainty among healthcare providers about the policies' legal status. Providers know that adopting one carries the threat of litigation.

When a healthcare organization adopts such a policy, its goal is to facilitate an agreement between the patient (or a surrogate) and the provider regarding the treatment proposed for the patient. If no agreement is reached, litigation may follow. The patient/surrogate or the provider may seek an injunction from the courts. Or the patient/surrogate may file a medical malpractice suit against the provider.

Malpractice Suits Physicians do not like to get involved in litigation. A physician who loses a malpractice claim risks both a damaged professional reputation and an increase in malpractice insurance premiums. Perhaps even worse, a report will be filed with the National Practitioner Data Bank noting that the physician has lost the suit.⁸ Since all hospitals are required to query the data bank on a regular basis, that report will follow the physician for the remainder of his or her career. Even if the physician should prevail in the lawsuit, he or she will be forced to spend amounts of time and money meeting with attorneys, answering interrogatories, appearing for depositions, and testifying at trial. No wonder, then, that the mere threat of litigation will deter some physicians from invoking a futility policy.

But such a policy does offer legal benefits to those physicians willing to risk litigation to preserve their professional integrity. Although a futility policy will not insulate the 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 malpractice suit, the plaintiff must prove that the treating physician breached the healthcare organization's standard of care. But an organization with a futility policy requires a consensus among its physicians that a

Adopting a medical futility policy carries the threat of litigation.

proposed treatment will not be beneficial to the patient. In any legal proceedings, such a consensus should be evidence that the standard of care was not breached.

Court Injunctions A patient/surrogate may file an action asking a court to order that treatment be administered even though it is deemed futile by the attending physician. Similarly, a provider may ask a court to issue

an order that treatment deemed futile *not* be initiated, or, if it has already been initiated, that it be discontinued, as in the Wanglie case.⁹ The court in such a case may be more inclined to agree that the treatment is indeed inappropriate if the physician involved has withheld or discontinued it in accordance with the organization's futility policy.

Mercy Health System, Conshohocken, PA, recently was involved in a case in which a patient's surrogate sought an injunction to get the patient treatment that the provider had decided was futile. Mercy did not then have a medical futility policy. Nevertheless, the case was instructive for those of us who became involved in it. It not only brought the issue of futile care sharply to our attention; it also gave Mercy an opportunity to assess where it stood on the issue from an institutional standpoint. The injunction was one we can expect patients/surrogates to seek on those occasions when an agreement on futile care cannot be reached.

This case concerned J. L., an 87-year-old woman who, over a period of months, had been admitted several times from a local nursing home to one of Mercy's acute care facilities. She had been ventilator dependent, semi-comatose, and in multiple-system failure for months before her first Mercy admission.

J. L. did not have an advance directive and, as a result, her wishes regarding her medical care were unknown to her healthcare providers.¹⁰ She had appointed both of her daughters as her healthcare agents. Unfortunately, the daughters had diametrically opposed viewpoints regarding their mother's medical treatment. One, S. A., argued that J. L. hoped to die peacefully and would never have wanted to be ventilator dependent. The other daughter, E. L., contended that her mother valued life and would have wanted all available life-sustaining measures employed to preserve it.

Each time J. L. was hospitalized at the Mercy facility, the daughters gave conflicting instructions regarding her medical treatment, thus putting her physicians in an unmanageable legal (as well as ethical) position.

Once, when J. L. was admitted because her feeding tube had become dislodged, E. L. insisted on immediate insertion of a central line and hyperalimentation. E. L. said that doing anything short of that would be tantamount to allowing her mother to starve to death. S. A., meanwhile, refused to consent to insertion of a central line, requesting comfort measures only. These conflicting instructions exposed J. L.'s providers to, on one hand, a possible criminal charge of battery if the central line were inserted, contrary to S. A.'s wishes—and, on the other hand, to a possible charge of negligence if they failed to insert the central line, contrary to E. L.'s wishes.

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Within 24 hours of the dislodging of the feeding tube, E.L. hired an attorney and filed an emergency petition for injunctive relief in the county court, asking the judge to order J. L.'s physicians to insert the central line and begin hyperalimentation. The judge issued the order and the physicians complied with it.

On her final admission, J. L.'s treating physicians found her to be in renal failure, with possible bowel ischemia, sepsis, and gastrointestinal bleeding. E. L. told the treating physicians to proceed with an exploratory laparotomy and dialysis. The attending surgeon said J. L. had less than a 1 percent chance of surviving the surgery. Dialysis also posed a serious risk because J. L. was already dangerously hypotensive and dialysis would further reduce her blood pressure. E. L. nevertheless insisted that both procedures be performed, since her mother would certainly die without them.

THE PROCEDURES OF MERCY'S FUTILITY POLICY

Physicians at Mercy Health System facilities follow these procedures in determining medical futility:

1. When the attending [physician] of record determines that an intervention is medically inappropriate but the patient (or surrogate decision maker) insists that it be provided, the attending of record should discuss carefully with the patient (or surrogate decision maker) the nature of the ailment, the options—including palliative care and hospice care—the prognosis, and the reasons why the interventions are medically inappropriate. The attending of record should explain that not providing the intervention in question does not mean abandoning appropriate medical care and humane care designed to promote comfort, dignity, and emotional and spiritual support.

2. The attending of record should address with the patient (or surrogate decision maker) the options of patient

transfer to another physician or to another institution and of obtaining an independent medical opinion concerning the medical inappropriateness or medical futility of the intervention in question. The attending of record should also provide the patient (or surrogate decision maker) with a copy of these guidelines.

3. The assistance of institutional resources (such as nursing, patient care representative, chaplaincy, social services) shall be made available to the patient (or surrogate decision maker) and to the attending of record.

4. If, after reasonable effort by the attending of record using the available institutional resources, agreement is not reached between the attending of record and the patient (or surrogate decision maker), the attending of record who still wishes to limit the intervention must request from the appropriate department director a second medical opinion from a

physician who has personally examined the patient. The second opinion must be appropriately documented in the patient's chart. Within 48 hours of obtaining the second opinion, the attending of record must prepare the case for review and forward it to the Institutional Ethics Committee. The attending of record must provide to that body clinical and scientific information pertinent to the determination that the intervention is medically inappropriate.

5. Within 48 hours after receipt of the case by the attending of record, the Institutional Ethics Committee must convene to hear the case. The attending of record and the patient (or surrogate decision maker) are requested to appear at the Institutional Ethics Committee meeting to represent their points of view. The Committee will render its recommendations no later than 24 hours after hearing the case. A representative of the

But S. A. would not consent to either procedure.

Once again E. L.'s attorney filed an emergency petition with the local court asking the hospital to be ordered to undertake "any medical or other care" necessary to preserve J. L.'s life. Although refusing to order surgery—because it would almost certainly have resulted in the patient's demise—the judge did order dialysis and "full resuscitation." Less than a week after the injunction, J. L. went into cardiac arrest. Complying with the court order and E. L.'s wishes, J. L.'s providers administered cardiopulmonary resuscitation for 45 minutes, without success. J. L. died.

Mercy would have avoided none of this litigation if it had had a medical futility policy. But such a policy would have given J. L.'s treating physicians a venue in which to present the facts of her medical condition and to predict the futility of the treatment E. L. requested. And if Mercy had then had, as it does today, an Institutional Interdisciplinary Review Board (IIRB) to make determinations on medical futility cases and if the IIRB had agreed that the proposed laparotomy and dialysis were futile, the treating physicians would at least have had the system's endorsement of their decision to forego treatment.¹¹

And if, moreover, Mercy had been able to introduce into evidence the fact that both its IIRB and Institutional Ethics Committee had

determined the surgery and dialysis to be medically futile, the judge might have agreed with those determinations and denied E. L.'s petition.

Futile treatment determinations today incorporate medical, ethical, social, and legal components. The debate centers on the conflict between individual rights (patient autonomy), on one hand, and the allocation of medical resources (social justice), on the other. But, in each case, the critical component is what the physician believes to be the patient's best interest. Absent statutory or appellate authority, physicians will have to balance the threat of litigation against their professional integrity in deciding whether to administer treatment they view as medically futile. Healthcare organizations should adopt futile care policies because, in doing so, they will not only provide their physicians with legal protection, they will also serve the best interests of their patients and society as a whole.

ETHICAL ANALYSIS

According to the dictionary, *futility* means "inadequacy to produce a result or bring about a required end; ineffectiveness."¹² The American Medical Association, however, says the concept "cannot be meaningfully defined."¹³ Essentially, futility is a subjective judgment but one that is indispensable.¹⁴

Institutional Ethics Committee will meet with both parties together to review and discuss the recommendations of the Committee.

6. In the event that both parties cannot reach a consensus after the recommendation of the Institutional Ethics Committee all information will be forwarded by the Institutional Ethics Committee to the Institutional Interdisciplinary Review Board (IIRB)* for adjudication.

7. The attending of record must notify the patient (or surrogate decision maker) in writing that the case has been forwarded to the IIRB, what it involves, what are its possible outcomes, when and where the review will take place, and that the option of transfer before the meeting exists, but that arranging such a transfer is the responsibility of the patient (or sur-

rogate decision maker). Absent patient (or surrogate decision maker) consent to an earlier time, the meeting cannot take place for at least forty-eight (48) hours after the patient (or surrogate decision maker) is notified.

8. During the IIRB process, the attending of record and the patient (or surrogate decision maker) are encouraged to be present together to express their views for consideration including alternative plans of care. This meeting of the IIRB should occur at the acute care facility where the patient is currently hospitalized to facilitate access to the patient and the patient's records.

9. If a finding of medical inappropriateness is affirmed by the IIRB, medically inappropriate intervention may be terminated and a plan of care established that addresses comfort care and the preservation of patient dignity. If, however, the IIRB does not concur with the attending

of record's determination of medical inappropriateness, the orders to limit the intervention will not be recognized as valid without patient (or surrogate decision maker) agreement.

10. If the IIRB agrees with the determination of medical inappropriateness, intrainstitutional system transfers of the care of the patient to another physician to provide palliative care are allowed. However, intrainstitutional system transfers to another physician to provide the intervention that has been judged by the IIRB to be medically inappropriate will not be allowed.

11. The procedures set forth in this policy may be invoked only by the attending of record or as otherwise authorized by the hospital's medical staff by-laws. Concerns on the part of other healthcare providers, hospital officials, or family members should be addressed through already existing institutional mechanisms.

* See above.

Within the medical community, there is a consensus that some treatments are medically futile, but consensus ends once you try to formulate an objective and concrete definition. As a result, "futile" interventions are sometimes confused with those that are harmful, ineffective, or impossible. It helps to distinguish among these concepts. According to two ethicists, James F. Drane and John L.

Coulehan, 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."¹⁵ However, until there is a clearer understanding of what medical futility means at the bedside, there will be no widespread agreement on definitions and implications of futility in general.¹⁶

Baruch Brody and Amir Halevy argue that four categories of medical futility set the parameters of the debate:¹⁷

Physiological Futility This, also known as quantitative futility, applies to treatments that fail to achieve their intended physiological effect. Determinations of physiological futility are based, not on vague clinical impressions, but on substantial information regarding the outcomes of specific interventions for different types of patients.

Imminent-Demise Futility This applies to treatments carried out despite the fact that the patient will clearly die in the very near future.

Lethal-Condition Futility This is treatment given to a patient who has an underlying lethal condition that the treatment cannot affect and that will result in death in the not-too-distant future (weeks or perhaps months) despite the treatment.

Qualitative Futility This is treatment that fails to lead to an acceptable quality of life for the patient. Qualitatively futile treatment may be successful in achieving an effect, but not, from the patient's perspective, one worth achieving.¹⁸

A consensus concerning the clinical features of medical futility remains elusive among healthcare

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professionals.¹⁹ But what these four categories emphasize is that decisions on medical futility must be made on a case-by-case basis and 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—whether, that is, it will 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 on the part of both the patient and the physician.

Patients have the right of self-determination to control their own medical treatment, but they do not have an absolute right to demand any medical treatment they happen to choose. And physicians have a duty to practice medicine responsibly. They are called to use professional norms, standards, and values as guidelines in making judgments on the appropriateness of medical interventions involving their patients—but they cannot make such judgments unilaterally. Medical judgments are never value free. In assessing whether a treatment is medically futile, physicians must consider carefully not only the values and goals of the patient/surrogate, but also those of the community, the institution, and society as a whole.

The question is: How does the physician balance all these values so that the best interest of the patient is always the central focus? We believe that the ethical principles of autonomy, beneficence, and justice provide a moral framework—a framework rooted in the Catholic moral tradition—for making medical and ethical determinations concerning medical futility.

Autonomy This is a person's right to exercise self-determination in making personal and informed choices. A patient has the right to choose and refuse medical treatments; a physician has the right to make choices based on his or her duty to practice medicine responsibly. Both patient and physician have the right of autonomy.

Legally and ethically, patients have been given the right to refuse medical treatments. This does not, however, imply that they also have the right of access to any medical treatment they choose.

Patients have the right to make medical decisions they believe are in their best interest—but such decisions may turn out to be destructive and irrational. It is at this point that patient autonomy conflicts with physician beneficence.

A physician cannot be forced to give medical treatment that he or she believes not in the best interest of the patient or of society as a whole. To do so would violate the physician's professional norms; he or she would have been asked to practice irrational medicine. To initiate or continue medical interventions even though the patient is no longer able to benefit from them is to confuse means with ends, effects with benefits, and available technologies with obligatory medical therapies.²⁰ This is not just an irrational act; it is also a morally irresponsible one.

The Christian view of autonomy focuses on the dignity and respect of every person. This does not mean that every person has absolute autonomy. As one physician has put it, "Respect for persons embraces self-governing decision-making. But our freedom as creatures of God is always within the constraints of ethical and moral determinants derived from Scripture, tradition, Church teaching, and the study of ethics."²¹ Allowing patients/surrogates to think that medical treatments are beneficent when they are in fact futile is to mislead them. This, write Drane and Coulehan, violates the principle of autonomy because "it creates a sphere of decision making where (rationally) none exists and, thus, seems intrinsically deceptive."²²

If a conflict between patient and physician precludes a decision by consensus, then the only option for the patient is to terminate the relationship and seek another physician. The physician has three options: He or she can arrange for the patient's transfer, seek a declaratory judgment in court, or act without the patient's approval. Litigation may ensue with the last option. But if the physician has acted according to generally accepted medical standards and/or in conformance with the expressed wishes of the patient, the physician will generally prevail.²³

Beneficence This involves one person's obligation to prevent or alleviate harm to another, to promote the good of the other by minimizing his or her burdens and maximizing his or her benefits. Beneficence includes the notion of nonmaleficence, which prohibits one from inflicting harm, injury, or death on other people.

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

Schneiderman and Nancy Jecker argue that for a treatment to be medically futile it has to be shown to have been useless either in the last 100 cases of the physician's personal experience or in published reports.²⁴ Treatment that merely preserves permanent unconsciousness or is incapable of ending dependence on critical care should also be considered futile. In judging futility, physicians must, moreover, distinguish between an effect (which is limited to a part of the patient's body) and a benefit (which appreciably improves the patient as a whole).²⁵ Physicians have an ethical responsibility to provide only those treatments to their patients which they believe to be beneficial, or at least not harmful or burdensome. To directly harm a patient violates both the Hippocratic Oath and the Christian notion of beneficence, which means doing good out of love for the person in need.²⁶

Of course, patients/surrogates must be permitted to determine whether the treatment will have a beneficial impact on the patient's life. Patients will generally make decisions that are rational and in their own best interests, but situations can arise in which their thinking is not rational. "Commitment to beneficence demands at least that physicians try to understand patients' intent and motivation and to influence them to make a rational decision," write Drane and Coulehan. "In some cases, physicians may choose not to act on patient decisions that appear to be unreasonably destructive."²⁷

As far as the patient is concerned, deciding whether a proposed medical treatment will be beneficial or nonbeneficial is an inescapably subjective act. It calls for a value judgement based on what the patient/surrogate believes is in his or her best interests. Physicians need to take the time to communicate with their patients in order to get a better understanding of the physical, emotional, spiritual, and financial values that govern their lives. The patient's values and goals should help inform a physician's decisions. But they must be considered along with—not instead of—professional standards concerning the appropriateness of a medical treatment. Only physicians have the expertise to determine whether a medical treatment is quantitatively futile. They should never comply with a patient's/surrogate's request to provide a treatment that is clearly physiologically futile, burdensome, and 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 the patient's values. Ideally, the physician and patient/surrogate should come to a decision together about the appropriateness of

a particular medical treatment and whether it will maximize the patient's benefits and minimize the burdens. 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 strong patient autonomy not only fail the test of beneficence; they may also fail the test of nonmaleficence at times.

Justice This principle says that all people should be treated fairly and be given their due. The issue of medical futility focuses specifically on distributive justice: the fair, equitable, and appropriate distribution of medical resources in society. One cannot remove a medical futility determination from the realm of social justice. At a time when reforming healthcare in this country has become a high priority, medical treatments judged to be futile and inappropriate are inconsistent with social standards and violate the principle of distributive justice. Access to basic healthcare for all Americans will never be realized if we continue to offer unreasonable medical care.

Although distributive justice is an important factor in the futility debate, it is rarely discussed. Mention the scarcity of resources and you will be accused of "putting a price tag on human life," which to most Americans is totally unacceptable. But is this realistic? Medical resources in this country *are* limited and must be conserved. Proper stewardship of these resources entails not wasting them on treatments that are futile and inappropriate. They must be rationally allocated; to waste them is ethically irresponsible and morally objectionable.

Critics argue that incorporating distributive justice in the medical futility debate is just a devious disguise for medical rationing. But 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 the distribution of treatments in the general population on a cost basis because of competing needs.²⁸ "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," write Nancy Jecker and Lawrence Schneiderman. "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."²⁹

As a matter of justice, patients/surrogates cannot be given the absolute right to demand

any medical treatment they choose. To do so would create a system that, according to one writer, "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."³⁰ If patients/surrogates were given the absolute right to demand inappropriate and nonbeneficial medical treatments, those treatments would be given at the expense of the poor, the powerless, and the marginalized—would be given, that is, unjustly. In this debate, failure to consider the allocation of scarce resources would itself be a grave injustice.

The medical futility debate comes down to a conflict between patient autonomy, on one hand, versus physician beneficence and distributive justice, on the other. Society cannot, in seeking a balance between the patient's goals and values and the goals and values of medicine, so inflate patient autonomy in importance as to destroy the principle of beneficence and overlook the equitable distribution of medical resources. To achieve this balance, physicians must agree on what constitutes a reasonable medical treatment and patients/surrogates must agree to restrict their self-advocacy to what is fair and equitable for all.³¹ The debate must focus on the best interests of the patient, without failing to recognize that every individual is also a member of society.

If, after carefully considering the patient's medical status, values, and goals, a physician believes 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 the treatment. The weighing of medical treatments on the basis of their benefits, burdens, and appropriate use as resources is firmly rooted in the Catholic moral tradition of the ordinary/extraordinary means distinction.

The Catholic tradition maintains that if a medical intervention is judged to be ordinary it is viewed as morally mandatory. If the intervention is judged to be extraordinary, it is morally optional. An intervention is said to be ordinary if it offers a reasonable hope of benefit for the patient and can 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.³²

Pius XII further clarified the ordinary/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 cul-

ture—that is to say means that do not involve any grave burden for oneself or another.”³³ Pius XII based the distinction between ordinary and extraordinary means on the idea that human life is a basic good—but a value to be preserved precisely as a condition 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.

Because of 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 appropriate, the Congregation for the Doctrine of the Faith concludes (in *The Declaration on Euthanasia*) that “it will be possible to make a correct judgment as to the means 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.”³⁴ This statement, 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.

MERCY'S MEDICAL FUTILITY POLICY

Unfortunately, an ethical justification for refusing or withdrawing medical treatments is not the same as a legal justification for doing so. Fear of legal liability naturally makes physicians hesitant to determine treatment to be medically futile, especially since there are as yet few legal precedents. “The evolution of case law in medical futility is still in its early stages, and the reaction from the courts has been mixed,” notes one writer. “In fact, it appears that the lower courts would rather not handle this complex problem at all.”³⁵

Adding to physicians' concerns is the fact that, to date, few hospitals have adopted policies that

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will support them in the event that they decide to deny a certain treatment because it is medically futile. Until ethical policies are formulated and the concept of futility is clarified, physicians will often continue to comply with patient's requests for medically inappropriate treatments—because the fear of malpractice hangs over them like the sword of Damocles.

Until recently, this was the case at Mercy Health System. But after dealing with a number of cases (including that of J. L., described above) in which surrogates or family members demanded—and physicians eventually felt compelled to provide—medical treatments that were clearly futile, Mercy decided in October 1999 to formulate a medical futility policy that would address physicians' concerns. We reviewed such policies from a variety of healthcare organizations. Since there seemed to be no consensus on a substantive definition of futility, we agreed to adopt the “Houston policy,” determining futility on a case-by-case basis.³⁶ This model appeared the most practical to implement.

Using the Houston model, we designed a procedural policy that is firmly rooted in the Catholic tradition, dovetailing it with a palliative care policy. We did this to make it clear that even though Mercy's physicians might determine a specific treatment to be medically futile, they would never abandon a patient. Each patient would be given appropriate care and would be treated with the utmost dignity and respect (see **Box**, p. 26).

We now plan to meet with the leaders of Philadelphia's other Catholic hospitals, hoping to persuade them to adopt Mercy's process-based approach to medical futility. Catholic hospitals are called to embrace Christ's healing mission, which means offering patients those treatments that will be beneficial to them. Such treatments should restore health, cure when possible, relieve pain and suffering, provide comfort care, and improve quality of life. We believe the system's futility policy will help physicians provide patients with medical treatments that are in their best interest, foster a responsible stewardship of healthcare resources, and provide the courts with a fair standard for adjudicating such cases. □

NOTES

1. Hippocrates, "On the Art," in W. H. S. Jones, trans., *Hippocrates*, vol. II, Harvard University Press, Cambridge, MA, 1981, p. 183.
2. In medical futility cases, the patient or surrogate wants to pursue the goal of preserving life even if there is little or no hope of improvement, and even though the other party, the treating physician, sees dying as inevitable and wishes to pursue the goal of comfort care. For a more detailed analysis, see the Council on Ethical and Judicial Affairs, American Medical Association, "Medical Futility in End-of-Life Care," *JAMA*, March 10, 1999, pp. 937-941.
3. For a more detailed analysis of both cases, see *In re Helga 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 the court in the Wanglie case never addressed the question of whether the physicians or the medical center could refuse to provide requested treatment. As a result, the issues of nonmaleficence versus beneficence, on one hand, and autonomy, on the other, were left unresolved.
4. See the Council on Ethical and Judicial Affairs, p. 938.
5. See Baruch Brody and Amir Halevy, "Is Futility a Futile Concept?" *Journal of Medicine and Philosophy*, April 1995, p. 124.
6. See James F. Drane and John L. Coulehan, "The Concept of Futility," *Health Progress*, December 1993, p. 31. See also Jane M. Trau and James J. McCartney, "In the Best Interest of the Patient," *Health Progress*, April 1993, pp. 50-56.
7. See Lawrence Schneiderman, Nancy Jecker, and Albert Jonsen, "Medical Futility: Its Meaning and Ethical Implications," *Annals of Internal Medicine*, October 1990, pp. 949-954.
8. 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 or more. See U.S.C.S., pp. 11,131-11,137.
9. See *In re Wanglie*, no. PX-91-283 (Minn. Dist. Ct., Probate Ct. Div., July 1, 1991).
10. Under Pennsylvania's Advance Directive for Health Care Act, a healthcare provider must either comply with a patient's advance directive or transfer the patient to another provider. See 20 Pa. C.S.A. 5401 et seq.
11. The IIRB determines medical futility cases in Mercy's four acute care facilities. The board, appointed by the system's senior vice president for medical affairs, comprises a physician, nurse, social worker, mission services representative, pastoral care worker, bioethicist, and legal counsel. When appropriate, a physician from the relevant specialty serves *ex officio* as a consultant.
12. *Oxford English Dictionary*, vol. IV, Oxford University Press, Oxford, England, 1989, pp. 626.
13. Council on Ethical and Judicial Affairs, *Code of Medical Ethics*, American Medical Association, Chicago, 1998-1999, p. 9.
14. Council on Ethical and Judicial Affairs, p. 938.
15. Drane and Coulehan, p. 29.
16. See Ronald E. Cranford, "Medical Futility: Transforming a Clinical Concept into Legal and Social Policies," *Journal of the American Geriatrics Society*, August 1994, p. 987.
17. Brody and Halevy, pp. 127-128.
18. See Glenn G. Greiner, "The Physician's Authority to Withhold Futile Treatment," *Journal of Medicine and Philosophy*, April 1995, p. 209.
19. "Whatever futility means, it seems obvious that this is not a discrete clinical concept with a sharp demarcation between futile and non-futile treatment," writes Cranford, p. 895.
20. See Lawrence Schneiderman, Nancy Jecker, and Albert Jonsen, "Medical Futility: Response to Critiques," *Journal of Internal Medicine*, October 15, 1996, p. 672. "In our experience," the authors write, "requests for futile treatment often represent not an appeal to respect the patient's wishes but rather a misguided effort to express caring for a patient by meeting a perceived need to 'do everything' when other manifestations of devotion (such as comfort care) would be more effective."
21. Edmund D. Pellegrino, "Christ, Physician and Patient: The Model for Christian Healing," *The Linacre Quarterly*, August 1999, p. 75.
22. Drane and Coulehan, p. 31.
23. See Edward R. Grant, "Medical Futility: Legal and Ethical Aspects," *Law, Medicine and Health Care*, Winter 1992, p. 334.
24. Lawrence Schneiderman and Nancy Jecker, *Wrong Medicine: Doctors, Patients and Futile Treatment*, Johns Hopkins University Press, Baltimore, 1995, p. 97.
25. In recent years, prognostic scoring systems (including the Acute Physiology and Chronic Health Evaluation—APACHE—system) have been developed to help physicians determine which of their patients are most likely to benefit from life-sustaining treatment. These use databases to predict the hospital mortality of patients who receive critical care. Depending on the decision criteria used, these systems have a positive predictive value of 80 percent and a negative predictive value of 90 percent. These values correlate well with clinical judgment in most cases. See John M. Luce, "Physicians Do Not Have a Responsibility To Provide Futile or Unreasonable Care if a Patient or Family Insists," *Critical Care Medicine*, April 1995, p. 761. See also Schneiderman, Jecker, and Jonsen, p. 952.
26. See Pellegrino, p. 75.
27. Drane and Coulehan, p. 29.
28. See Council on Ethical and Judicial Affairs, p. 938.
29. Nancy Jecker and Lawrence Schneiderman, "Futility and Rationing," *JAMA*, February 1992, p. 195.
30. Luce, p. 764.
31. Luce.
32. According to a classic interpretation of the ordinary/extraordinary means distinction, "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." Gerald Kelly, *Medico-Moral Problems*, Catholic Hospital Association, St. Louis, 1958, p. 158. Emphasis in the original.
33. Pius XII, "The Prolongation of Life," *Acta Apostolicae Sedis*, 1957, p. 1,032.
34. Congregation for the Doctrine of the Faith, "Declaration on Euthanasia," *Origins*, August 1980, p. 263.
35. Cranford, p. 896.
36. See Amir Halevy and Baruch Brody, "The Houston Process-Based Approach to Medical Futility," *Bioethics Forum*, Summer 1998, pp. 10-17.