

Evaluation of Capacity in the Hospital Setting and its Long-Term Implications

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Case presentation:

History of present illness:

A 37-year-old male presented to our urban community emergency department by ambulance with a chief complaint of a cough and blood-tinged sputum.

Past medical history was remarkable for a prior cardiac arrest secondary to aspiration, polysubstance use disorder, person who uses intravenous drugs, person without a home, aortic and mitral valve endocarditis, heart failure with reduced ejection fraction, bicuspid aortic valve, 4.7 cm ascending thoracic aneurysm of the aorta, and hypothyroidism.

The previous hospitalization from January 19 to February 4 was due to a cardiac arrest secondary to an aspiration event later complicated by septic shock and acute renal failure. At that time, a transthoracic and transesophageal echocardiogram showed aortic and mitral valve vegetations consistent with endocarditis. Also noted was severe global hypokinesis with a left ventricular ejection fraction of 25-30%. Blood cultures had no growth, and the patient was empirically started on cefepime and daptomycin. The patient was to be evaluated by Cardiothoracic surgery; however, he stated he would rather die than have open heart surgery. Psychiatry was consulted and deemed the patient to have the capacity, and the patient left against medical advice.

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+To cite this article: Weisner, Z.M., Collins, E., Hanson, K., Patrick, H., Clark, P. "Evaluation of Capacity in the Hospital Setting and its Long-Term Implications". *The Journal of Healthcare Ethics & Administration* Vol. 10, no. 1 (Winter 2024): 1-9, <https://doi.org/10.22461/jhea.4.71614>

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The patient was re-admitted from February 5 to February 12 due to profound hypothermia at 78 degrees F. The patient was warmed with IV fluids and placed in a bear hugger. A repeat transthoracic echocardiogram was obtained, which revealed severe left ventricular systolic dysfunction and an estimated ejection fraction of 34%. Again, the patient was restarted on IV antibiotics. Unfortunately, the patient felt better and chose again to leave against medical advice as the primary team believed the patient had capacity at that time.

Hospital Course:

On this hospitalization, the patient was admitted on February 15 due to a cough with blood-tinged sputum. The patient had acute renal failure with hyperkalemia and a high anion gap metabolic acidosis. The patient eventually became oliguric and fluid-overloaded, requiring a dialysis catheter placement and hemodialysis. The patient received one hemodialysis session with subsequent improvement in renal function.

The patient became hemodynamically unstable, suspected to be related to cardiogenic shock. An arterial line was placed and connected to the flow track to obtain additional information. Unfortunately, the arterial waveform was inaccurate due to the bicuspid aortic valve and vegetation. The dialysis catheter was exchanged for a sheath introducer to evaluate the patient's hemodynamics, and a right heart catheterization procedure was performed. A Swan-Ganz catheter was placed, revealing the following information: CVP of 13 mmHg, RV 54/12, PA 54/32, PAOP unable to measure. SmVO₂ 24%, cardiac index 2.4 L/min/m², SVI 50 mL/b/m² and RV EF of 30%. These measurements allowed us to increase the Milrinone drip from 0.3 to 0.4 microgram/kilogram per minute, improving SmVO₂ to 50% and CI 4 L/m/m².

The patient has agreed to diagnostic investigation and treatment to this point. However, he became agitated and wished to leave against medical advice. Our critical care team assessed that this patient was oriented but needed to understand the risks, benefits, and insight into his disease. Because the patient lacked capacity, all medical decisions were made by the patient's next of kin, his mother, as determined by the State of Pennsylvania ACT 169. After a family discussion, the mother was agreeable to serve as the patient's healthcare representative.

A multidisciplinary discussion was held with infectious disease, cardiology, and care management. We will continue the daptomycin and ceftaroline to treat the culture-negative endocarditis until March 15, after which the patient can be evaluated by cardiothoracic surgery. We planned to continue the milrinone drip and initiated a beta blocker to support the patient's cardiac function. We also arranged for a life vest due to the severe heart failure with reduced ejection fraction. A dual-lumen, non-tunneled PICC line was placed. Furthermore, a psychiatric consult was arranged who agreed with our initial assessment that the patient lacked the capacity to make medical decisions.

At this point, the patient was agreeable to participate in a drug rehabilitation program. We will arrange for a cardiac surgical evaluation for a potential valve replacement after antibiotic therapy. Should the patient continue to utilize substances or not be a candidate for surgery, he was deemed to have an end-stage condition secondary to heart failure and endocarditis. Therefore, the patient would be a candidate for hospice care.

On March 10, the patient was downgraded from the ICU to the medical floor. However, he subsequently experienced a cardiac arrest due to a presumed clogged PICC line, resulting in the cessation of the milrinone drip. After four rounds of CPR, a return of spontaneous circulation was obtained. The patient was re-upgraded to the critical care unit.

When the patient's mother (his next of kin) was made aware of this update, she threatened suicide, and we arranged for the police to do a welfare check. The patient's sister was made next of kin. We arranged for a transfer to Jefferson Abington Hospital to their advanced heart failure service, hoping for cardiac surgery to address his underlying endocarditis. Due to the patient's intention to continue using IV drugs, he was not deemed a surgical candidate.

When the patient arrived at Abington, he was re-evaluated for infectious disease, and additional studies were sent. The patient experienced a fourth cardiac arrest and was successfully revived after two rounds of CPR. A repeat transthoracic echocardiogram was performed, and there was a concern for triple valve endocarditis (TV/MV/AV), suggesting progression. He was found to be a very high risk and not a current surgical candidate. The patient was transferred to the critical care service.

The infectious disease was followed, and additional testing showed positive titers for *Bartonella henselae* (titer 1:512) and quintana (titer 1:128). However, titers < 1:128 can be seen in the general population. Furthermore, *Bartonella* endocarditis is associated with small vessel vasculitis with a positive cytoplasmic antineutrophil cytoplasmic antibody (c-ANCA), anti-proteinase 3 antibodies (anti-PR3) and or kidney injury with glomerulonephritis. These conditions resolve with treatment. The patient was started on doxycycline 100 mg BID and rifampin 300 mg BID, which will need to be on for eight weeks.

Due to progressive hypotension, milrinone was discontinued, and dobutamine was added. A thoracentesis was performed to help treat ventilator-dependent respiratory failure, and the patient was successfully extubated. The patient was evaluated by vascular surgery for gangrenous toes. A lower extremity arterial ultrasound showed an anterior tibial artery thrombus, and the patient was started on a heparin infusion.

The patient was noted to have rising creatine with oliguria concerning worsening renal failure. A bicarbonate drip was added to help treat the metabolic acidosis. Nephrology initiated continuous renal replacement therapy. Unfortunately, the patient became hypotensive with evidence of shock liver on laboratory analysis. The patient had an additional cardiac arrest in which ROSC was obtained—hemodynamic support adjusted to include norepinephrine, dobutamine, vasopressin, phenylephrine, epinephrine, and dopamine. The patient was noted to have severe tricuspid, mitral, and aortic regurgitation. The patient is not a candidate for any invasive intervention. Unfortunately, the patient continued to decompensate and went into an additional cardiac arrest and expired.

Comments on the Ethics of this Case:

Zachary Weisner Position:

Medical innovation has strained the boundaries of the Hippocratic Oath. With life-prolonging therapeutics and the concept of informed consent, we have veered from a paternalistic approach in medicine toward the shared decision-making model. I have often found this practice valuable, as a healthy dialogue with the patients and their families on appropriate treatments for their ailment usually abides by the four ethical principles of healthcare. This case was discordant between patient care goals and perceived outcomes. Multiple and extensive attempts were made to educate the patient on his condition. Still, he undoubtedly lacked capacity as he had no understanding of risk and benefit and had poor medical insight toward the severity of his condition. Upfront, this patient received a prolonged dose of ceftaroline and daptomycin without understanding what we were treating. Complicating this, the patient had multiple social determinants of health with evident medical illiteracy.

The patient's mother and father could assume care per PA Act 169. The father, however, relinquished his rights. The patient's mother rarely visited and was repeatedly unwilling to address hospice or a do-not-resuscitate order. While I support her rights as next of kin, there was no genuine dialogue regarding this patient's care; she wanted him to live. Her role as next of kin became incredibly complicated when she threatened to commit suicide over the phone, and we had to call the police. From my standpoint, the mother was not acting in the patient's best interest. However, multiple lawyers from our risk management team believed it appropriate to maintain her authority. Despite this, had the patient remained stable after receiving a proper duration of antibiotics to treat his *Bartonella* endocarditis and participated in a brief rehab, and had the patient had an adequate support system and rehabilitation service, offering a valve replacement against the patient's wishes would have been appropriate. Valve replacement is the only definitive care for endocarditis—multiple physicians at two facilities deemed the patient lacking capacity. Doing anything in the middle causes undue suffering to the patient. Despite this patient having a long history of substance use disorder, multiple social determinants of health, and poor medical literacy, does he still not get the right? While I recognize the controversy surrounding this question, if we genuinely believe this patient is lacking capacity, is there not an argument that they deserve the same treatment as every patient?

Alternatively, suppose this patient was utterly unwilling to participate in drug rehabilitation and lacked appropriate care following a valve replacement. In that case, embracing the concept of medical futility would be more than reasonable. Transitioning the patient to hospice allows the patient to have a peaceful experience proceeding with death with his family. Futility has historically been challenged in the United States for violations against constitutional rights, the Emergency Medical Treatment and Labor Act (EMTALA), and the Americans with Disabilities Act (ADA). We have yet to nationalize process for futility policies like the National Health System in England, where cases deemed futile are often upheld. Instead, futility policy here in the United States is subject to individual healthcare

centers and is at the mercy of large organizations and vast legal opinions. The patient, often in the middle of these long, drawn-out processes, is often the one to suffer.

Above all else, my position is this: failure to arrive at a plan for either a valve replacement or hospice resulted in this patient experiencing vast agony due to a prolonged hospital course and seven cardiac arrests.

Ethan Collin's Position:

Having been introduced to this case during the patient's 3rd admission to the hospital, it took several days and numerous meetings with the patient to understand the ethical struggle of this current and prior hospitalizations. Over the course of my caring for the patient, his capacity and general mentation waxed and waned frequently. At times, he would go from having the capacity for consent and understanding the goals of how our procedure works to being minimally rousable by the afternoon.

In these instances, the assessment of capacity is quite fluid. Here, the patient had several prior hospitalizations where he was deemed to have capacity and left against medical advice (AMA). During these previous hospitalizations, there was continued documentation of the patient's wishes, which included not being hospitalized and wishing to go home so he could continue intravenous drug use. Similarly, during the brief windows where I deemed him to have capacity, he did express similar wishes.

I think it is best to reflect on a contextual patient that hospital medicine is apt to encounter. We have a 90-year-old woman with Parkinson's dementia as well as advanced heart failure. She is currently admitted for cardiogenic shock, requiring inotropic support and bi-level positive pressure ventilation with acutely worsening mentation. While no prior code status nor advance directives have been established, many physicians would quickly discuss a do-not-resuscitate or do-not-intubate order with the next of kin. In the best circumstances, there is an accessible and cooperative next of kin who are able to portray the patient's wishes to which we would tailor care.

In the example, we are able to care for the patient while being congruent to her previous wishes as communicated by the family. However, in our case presentation, we could not rely on the next of kin to communicate the patient's wishes, as discussed by Dr. Weisner above. It was crucial to establish the patient's advance directives while we had times of capacity.

I find that his GOC was well established even prior to this current hospitalization when he chose to leave AMA several times. He also reiterated his desire to leave the hospital to continue intravenous drug use at home while, in my view, understanding the mortality of his current medical condition. I believe many readers would find this understandable up until his desire to use intravenous drugs as it is incongruent with societal norms while at the same time normalizing the usage of alcohol and, increasingly, cannabis, which are arguably substances with similar addictive properties.

In palliative medicine, we attempt to parse out what meaningful life is for a patient. In my assessment of our case, meaningful life to the patient is to continue intravenous drug use to which he has expressed an understanding of the dangers of such activity and awareness of foregoing treatment of his medical condition at hand. Where is it our job to stop individuals from using intravenous drugs who express an understanding of the risks?

Our role in medicine is to offer avenues of treatment and properly educate patients regarding the risks and benefits of treatment and the risks and benefits of non-treatment. We are to no longer pursue futile care for extended periods against the patient's wishes, nor are we to withhold life-prolonging care to those informed. Here, the patient has previously expressed and shown his informed wishes but had lost capacity. We should continue to honor those wishes to the same extent that we honor a dying elder who wishes to remain comfortable, regardless of age, race, or perceived social detriments of health.

Case Commentary

Peter A. Clark, Ph.D.

From an ethical perspective, this case is a good example of medical futility. The patient has an end-stage condition, is non-compliant, and we continue to treat him aggressively. 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

from 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 patient's 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

According to the dictionary, *futility* means "inadequacy to produce a result or bring about a required end; ineffectiveness."⁸ The American Medical Association, however, says the concept "cannot be meaningfully defined."⁹ Essentially, futility is a subjective judgment but one that is indispensable.¹⁰

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."¹¹ 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.¹²

Baruch Brody and Amir Halevy argue that four categories of medical futility set the parameters of the debate:¹³

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 a 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.¹⁴

A consensus concerning the clinical features of medical futility remains elusive among healthcare professionals.¹⁵ 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 carefully consider 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 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 to 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 to access 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 is 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.¹⁶ This is not just an irrational act; it is also a morally irresponsible one.

If a conflict between the 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.¹⁹

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.²⁰ 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).²¹ Physicians have an ethical responsibility to provide only those treatments to their patients that 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.²²

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."²³

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 judgment 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 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.²⁴ "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."²⁵

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."²⁶ 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 the 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, inflate patient autonomy in importance so 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.²⁷ The debate must focus on the best interests of the patient without failing to recognize that every individual is also a member of society.

Conclusion: 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 the treatment to be medically futile, especially since there are few legal precedents as yet. "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."²⁷

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

Endnotes

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 of 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, March 28 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 of 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 *Oxford English Dictionary*, vol. IV, Oxford University Press, Oxford, England, 1989, pp. 626.

⁹ Council on Ethical and Judicial Affairs, *Code of Medical Ethics*, American Medical Association, Chicago, 1998-1999, p. 9.

¹⁰ Council on Ethical and Judicial Affairs, p. 938.

¹¹ Drane and Coulehan, p. 29.

¹² 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.

¹³ Brody and Halevy, pp. 127-128.

¹⁴ See Glenn G. Greiner, "The Physician's Authority to Withhold Futile Treatment," *Journal of Medicine and Philosophy*, April 1995, p. 209.

¹⁵ "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.

¹⁶ 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."

¹⁷ Edmund D. Pellegrino, "Christ, Physician and Patient: The Model for Christian Healing," *The Linacre Quarterly*, August 1999, p. 75.

¹⁸ See Edward R. Grant, "Medical Futility: Legal and Ethical Aspects," *Law, Medicine and Health Care*, Winter 1992, p. 334.

¹⁹ Lawrence Schneiderman and Nancy Jecker, *Wrong Medicine: Doctors, Patients and Futile Treatment*, Johns Hopkins University Press, Baltimore, 1995, p. 97.

²⁰ . 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.

²¹ See Pellegrino, p. 75.

²² Drane and Coulehan, p. 29.

²³ See Council of Ethical and Judicial Affairs, p. 938.

²⁴ Nancy Jecker and Lawrence Schneiderman, "Futility and Rationing," *JAMA*, February 1992, p. 195.

²⁵ Luce, p. 764.

²⁶ Luce.

²⁷ Cranford, p. 896. See Amir Halevy and Baruch Brody, "The Houston Process-Based Approach to Medical Futility," *Bioethics Forum*, Summer 1998, pp. 10-17.