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Community Ethics

The CEP is a cooperative effort of the University of Pittsburgh Center for Medical Ethics and the Hospital Council of Western Pennsylvania

CEP FACULTY PARTICIPATE IN SHHV ANNUAL MEETING

Rehab Ethics Group Unveiled

The faculty of the University of Pittsburgh Center for Medical Ethics have always contributed to the national scholarly community both through publications and activity in professional organizations. Participation in the major bioethics societies is important to hone one's own scholarly skills; but of far more import to faculty who teach in the CEP, such involvement is also a chance to tap different perspectives and sources of information that can be useful here at home. Of course, the Consortium Ethics Program prides itself on bringing the best that bioethics has to offer to our members in Western Pennsylvania.

Once again, the faculty of the Center for Medical Ethics (including many of the CEP's core faculty), were very involved in the annual meeting of the Society for Health and Human Values (SHHV), the oldest and possibly most prestigious of national bioethics organizations. The Director of the CEP, Rosa Lynn Pinkus, Ph.D., presented a paper entitled, "Neurosurgery's Tacit Ethical Dimension: The Evolution of Moral Reasoning." This paper echoed a theme familiar to those acquainted with Dr. Pinkus' work: ethics are implicit within clinical practice and often have a history that is coextensive with the needs of particular specialties. Mark Kuczewski, Ph.D., Associate Director of the CEP, presented the paper, "One Case, Two Tales: The Casuist and Communitarian as Ethics Consultants." A number of other faculty and associates of the Center for Medical Ethics/Consortium Ethics Program also presented papers or conducted workshops. These included Bob Arnold, M.D., Rachel Majeske, M.A., Lisa Parker, Ph.D., Joel Frader, M.D., Judith Erlen, Ph.D., R.N., Jack Coulehan, M.D., M.P.H., and Donald Ainslie, M.A.

Mark Kuczewski also helped organize and served as moderator for the first annual session of the Rehabilitation Ethics Interest Group of the SHHV. Mark co-founded this group with Ruth Bryant Purtilo, Ph.D., P.T., of Creighton University, to create a resource on ethics in rehabilitation care and to assist rehabilitation professionals around the nation and in the CEP. The first meeting of the interest group was attended by approximately 20 people. Two presenters gave brief didactic presentations and led discussions. Dorle Vawter, Ph.D., Associate Director, Minnesota Center for Healthcare Ethics, reviewed the literature and explained its strengths and shortcomings. Kate Brown, Ph.D., Associate Professor of Occupational Therapy, Creighton University, discussed the teaching of rehabilitation ethics and provided anthropological insights on the need to adapt the culture of medical ethics to that of rehabilitation professionals. The discussions that followed were highly interactive and energetic.

Next year's meeting of the SHHV (co-sponsored by the Society for Bioethics Consultation) will be held in Cleveland on October 10-13, 1996. Mark your calendars!

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In This Edition:

Futility has become a kind of medical ethics shorthand for non-beneficial treatment that a physician wishes to terminate or withhold without the consent of a patient/surrogate or against the wishes of the patient or his surrogate (you see the need for a shorthand). This topic has been debated in the literature for several years and a few hospitals around the country have created and implemented futility policies. Because this is a hotly contested topic, this issue of *Community Ethics* (*CE*) brings you both sides of the issue. We are pleased to present an article by Stephen Wear, Ph.D., Benjamin Phillips, R.N., Sally Schimmel, R.N., and John Banas, M.D., relating their experience with such a policy at the Veteran's Administration Medical Center in Buffalo, NY. We also feature the cautionary reflections of Brad Wilson, Ph.D., on the topic. Interested readers are advised to see Alan Joyce's "Truly Useful Literature" column for further sources of information on this important issue.

Also, to help convey the flavor of the recent, highly successful, CEP retreat, we include excerpts from two fine presentations on ethical issues in **managed care.** We hope to provide further insights on ethics and managed care in future editions of *CE*. As always, we welcome any contributions our readers wish to make along these lines.

- Mark Kuczewski, Ph.D., *Editor*

Developing and Implementing a Medical Futility Policy:
One Institution's Experience

by Stephen Wear, Ph.D., Benjamin Phillips, R.N., Sally Shimmel, R.N.and John Banas, M.D.
Ethics Advisory Committee, Veteran's Administration Medical Center, Buffalo, NY

Mr. R is a 63-year-old male with a history of cardiac problems and cardiac angioplasty six years ago. On the day of admission, the patient suffered a cardiac arrest at home and was resuscitated by EMS after about 20 minutes. Admitting diagnosis was anoxic encephalopathy. Two years later, the patient is in a CCU/step down unit in a persistent vegetative state on full life support. His wife and son visit and/or phone daily inquiring about his condition.

Numerous attempts to get the family to accept the profound nature of the patient's catastrophe have been completely unsuccessful. At this juncture family queries regarding how the patient is doing are, by design, met with blunt statements that he is "not doing well", and some of this is specified, i.e. he has frequent UTIs, his kidneys are failing, his skin is breaking down despite strenuous nursing response, and it is becoming more difficult to obtain blood.

During daily visits, the son might state "Daddy's color looks great today"; the nurse responds "your father has a temperature and he looks flushed". The wife says " my husband talked to me today"; the nurse responds: "you heard air escaping from around his trach tube". The son says "Daddy moved his hand when I touched him"; the nurse responds: "your father always responds to any tactile stimulus". Despite such routine negative reinforcement, the family continues to smile and turns away when staff disagrees with them or offers a poor prognosis. The patient remains a "full treat" at the family's insistence.

Roughly three years ago, our institution's ethics advisory committee began developing a policy to advise and support staff with regard to certain types of troublesome, recurrent cases in our institution. The sorts of cases at issue were generally within the area of what is referred to as futile treatment, viz. where patients and/or families continue to demand treatment that is seen by staff as without benefit to the patient, even in the face of strenuous counseling to the contrary. In what follows, we will describe the motivations and concerns that drove the development of this policy, present the policy which was eventually developed, and then detail our subsequent experience with its implementation.

I.
WELL SPRINGS OF OUR MEDICAL FUTILITY POLICY

Health care providers, at this late date, can hardly be unacquainted with futile treatment. Either through their own experience, those of colleagues, or minimal exposure to the professional literature, the provision of non-beneficial, often burdensome treatment, has approached the routine. The causes of this are various, including the fact that adequate prior discussions and orders are not generated, or that some party, e.g. the doctor, patient and/or family, had insisted on them, has approached the routine. Whether it be the end stage, moribund patient who gets resuscitated in the dead of night, or the patient in persistent vegetative state who continues to get full intensive care, the examples and numbers here are legion.

Many have tried to change all this in various ways. Legal and institutional activism has resulted in the development of living wills -- and more recently, the designation of health care proxies -- to deal with such scenarios up-front. Increasing numbers of institutions and individual practitioners have sought to incorporate the solicitation of such advanced directives, formal or otherwise, into their routine interactions with patients. Ethics committees and consultants have increasingly entered the clinical arena to advise, counsel and support staff, patients and families in responding to the often poignant and difficult "end of life" decisions that contemporary medical progress has made a common feature of the health care experience. Concurrent discussions in the bioethics literature, as well as legal initiatives, have resulted in sorting a great deal of this out with substantial progress made in providing those concerned with options and guidance. To a great extent, the earlier "treat at all costs and to the bitter end" philosophy has evaporated as has the parallel problem that anyone who attempted to abate treatment for devastated and/or dying patients did so in situations of at least perceived if not real legal jeopardy.

For all the progress, however, we are still speaking of a battle that must be re-fought daily; like freedom, it calls for ongoing vigilance. It will always remain easier to default into continued aggressive treatment and thereby avoid the wrenching discussions that must occur if such treatment is to be abated. And even where such discussions are initiated, there is no guarantee that they will issue in results that are acceptable, beforehand or after, to all parties. But at least the "vitalist" mentality has been beaten back, and the law no longer prohibits what many of those at the bedside agreed was simply and obviously appropriate, i.e., the abatement of non-beneficial treatment.

The current futility debate, beyond all such progress noted above, may be interpreted in a variety of ways. For some, it is a last vestige of medical paternalism. Others may see it as the residue of the law's inability to come to terms with medical failure. Still others emphasize the inability of patients and/or their families to be realistic. And it is surely the case that no consensus, within the bioethics literature or at the bedside, currently exists. Nor is there any clear legal guidance to appeal to, as the courts have fallen on both sides of this issue. In parallel, clinicians hold forth on both sides of the professional debate as to whether there is any such thing as futile treatment, at least to the extent that physicians should

have the authority to diagnose it and, as a result, unilaterally withhold it. The practical result is that, at least in the eyes of its proponents, medically futile treatment is still often demanded and provided over the counsel and protests of health care providers.

Our ethics committee stepped into this morass about three years ago. Attesting to the realism of the debate in the bioethics literature, it soon became apparent that the sorts of cases motivating our membership fell roughly into two basic groups which this debate had already identified, viz. quantitative (or physiological) and qualitative futility. We were thus generally concerned with cases where either (1) a treatment would not be successful in generating the result for which it was ordinarily used, e.g., CPR for cardiopulmonary arrest as a result of end stage cardiogenic shock, or (2) even if the treatment might successfully produce the clinical effect for which it was designed, it would still fail to benefit the patient, e.g., ventilatory support for the persistently vegetative patient.

We all brought many examples of both types of futility to the discussion. Some examples were well known to all of us as the ethics committee had been intimately involved in the cases, e.g., a number of patients, having suffered profound encephalopathy from extended anoxic events, were then maintained for years on end by full life support at the families' insistence. Both the exhaustive (and exhausting) efforts of staff to assist families to see the "futility" of further aggressive treatment and the complete lack of success in these endeavors were well-known and documented in a number of cases. We all agreed that a significant number of futile cases had occurred and that they had not been satisfactorily resolved. Obviously, something beyond our quite active support and counseling service was needed. In sum, what was needed was a policy to justify unilaterally withholding futile care over the objections of patients and/or their families.

II.
DEFINING FUTILITY

We began by spending considerable time trying to develop a "definitional" policy, i.e. a policy that sufficiently defined futile cases so that all that staff had to do was document that the necessary and sufficient conditions for a futility judgment were present to proceed to unilateral abatement of the treatment. As anyone who has tried to develop clinical guidelines knows, it is imperative to be precise enough that clinicians receive sufficient guidance and support, while at the same time the possibility of abuse or error is minimized. In addition, such a policy must have sufficient flexibility so that management does not become knee-jerk, but retains enough flexibility to respond to the unique characteristics of a given case.

Our attempts to generate a "definitional" policy met with conceptual, but not operational, success. We defined futility as "any treatment which fails to provide either cure, restoration or palliation to a patient." There was no real disagreement here, but consensus evaporated as soon as we started to discuss how such elements were to be identified or to worry about the corollary goals of minimizing abuse and error and providing sufficient clinical flexibility.

Every definition we reviewed was seen as having some significant flaw in formulation that made it problematic as a clinical guideline. Statistical definitions were considered inadequate on a number of scores, including the fact that statistical accuracy is class-based, not individual-based. It is often fairly conjectural (particularly when applied to any individual), and often opposed by anecdotes that are "exceptions to the rule." For instance, a less than 1% recovery rate from triple organ failure still leaves some true recoveries. Equally, the same statistics regarding resuscitation for patients with end stage metastatic disease still have contrary anecdotes to face.

Definition by clinical diagnosis, e.g., severe stroke or anoxic encephalopathy, as well as by their parallel functional description, e.g., irreversible coma or persistent vegetative state, was also seen as requiring judgment calls beyond what any policy description could exhaustively capture. All such attempts at describing precise clinical parameters were seen as problematic for ancillary reasons, i.e., that though a given patient might clearly qualify under some definition, we still might not want the policy option of unilateral abatement exercised. Here's what we meant: if we had a situation where the patient was immanently dying -- and beyond all suffering -- it seemed to us that confrontation with the family in that situation simply lacked compassion (and did so in the absence of strong reasons to proceed). Equally, in the event that the patient and/or family had not been adequately assisted by staff up-front to come to terms with the patient's situation and prospects, the exercise of unilateral abatement would be simply unfeeling and unfair.

There is a crucial generic point here that we came to insist upon: that even if futility was clear, other conditions also had to be met to warrant unilateral withdrawal. Before overruling the patient's or family's rights to make such decisions, we felt obliged, to the extent there was time and opportunity, to give them a chance to come to terms with matters themselves. This was not always possible, but at least institutionally, all other avenues had to have been explored first.

We believe that any institution that is contemplating a futility policy must first have an aggressive "preventive ethics" and ethics consulting program in place to legitimize moving to the unilateral futility option. Absent this, a futility policy would just be brutish and uncompassionate, as well as create an "easy out" for those who continue to fail to talk to their patients and families up-front. A futility policy must be part and parcel with a much broader ("kinder and gentler") preventive effort. By itself, it would probably be no more than that last vestige of medical paternalism that many fear and would tend to remove needed incentives to early discussion and counseling.

Now, while we did not adopt a definitional policy per se, substantial progress has occurred as a result of deliberating over a definitional policy. We knew that we would want independent confirmation of any futility "diagnosis". We

also knew that we might not want the futility option exercised even where it was abstractly clear that the treatment was futile, e.g., immanent death in a completely obtunded patient. But we also knew that without specific definitions, the policy would have an abstractly arbitrary character, as if we did not really know what we were talking about. So the next phase of our deliberations concerned whether we could generate a procedural or process-based policy where, although we could not provide a clinically precise definition up-front, we might still be able to design a process where legitimate agreement at the end of the assessment of a specific patient might be produced. The result was, in fact, the "process" policy which we will now state and discuss.

III.
A MEDICAL FUTILITY POLICY BASED ON PROCESS

Our futility policy is stated within our "Limitations of Treatment" policy, which deals with everything from DNR and non-arrest limitations of treatment orders, to ethics consultation, and the evaluation of prior statements and proxy decision makers. Two basic sections regarding medical futility occur within this policy, i.e., an initial generic statement is made in the "Definitions" section, and then a more detailed description of the procedural response to alleged futile cases is offered in the "Procedures" section. The definitional section states:

> *"Medically Futile: (a) Futility means any treatment that, within a reasonable degree of medical certainty, is seen to be without benefit to the patient, as when the treatment at issue is seen as ineffective with regard to a clinical problem that it would ordinarily be used to treat. An example of this would be CPR for a patient with cardiac rupture or end-stage cardiogenic shock. (b) Futility judgments may also be made in such cases wherein treatment provides neither palliation, restoration or cure. An example of this would be hemodialysis or CPR for a permanently unconscious patient."*

Note that the definition proceeds both by generic policy statement as well as by example. As previously noted, neither was thought to provide sufficient clinical guidance by themselves. They were felt, however, to provide sufficient guidance for the *identification* of potentially futile cases for the purpose of then initiating the process by which such a judgment is to be assessed. That process was described in the "procedures" section of our "limitations of treatment" policy as follows:

> *"The judgment that a given treatment, or aggressive treatment in general, is medically futile may be made by the patient's attending physician and treatment unilaterally withheld or withdrawn without patient or surrogate consent when the following steps have been accomplished:*
>
> *(1) Another attending physician, other than a physician member of the VAMC Ethics Advisory Committee (EAC), has concurred with the futility judgment.*
> *(2) Two members of the Ethics Consultation team or the EAC have consulted on the case.*
> *(3) The Chief of Staff concurs with the judgment of futility.*
> *(4) The patient or, if incapacitated, the patient's surrogate, has been notified of this judgment and has been appropriately counseled as to its implications.*
>
> *After completion of the process described above, but before the proposed action is taken, the attending physician will inform the patient, the patient's legal representative or surrogate, of the options open to them:*
>
> *(a) that the patient may be transferred to another facility;*
> *(b) that the cost of arrangements for such transfer will be borne by the patient, the patient's legal representative or surrogate; and*
> *(c) that the patient, the patient's legal representative or surrogate has the right to challenge the decision by petitioning the appropriate court to enjoin the Medical Center from abating the action(s) it has determined to be medically futile.*
>
> *Given the serious and unilateral character of such judgments, a formal hearing by the Ethics Advisory Committee should generally also occur between steps 2 and 3, TIME PERMITTING. In any case, a full retrospective review of any such futility judgment must be conducted by the Ethics Advisory Committee at least by its next monthly meeting."*

The discussion of what such a process amounts to is better left to the next section where we will detail our experience with this policy once it had been implemented. Suffice it to say, at this juncture, that aside from incorporating the input of relevant parties in the process, the aims of the policy include **making sure that the futility claim is well based scientifically** (step #1: concurrence by another attending physician), **confirming that adequate counseling had already been attempted toward removing the disagreement** (step #2: consultation by EAC members), and **securing institutional support** (step #3: approval by Chief of Staff). Conclusion of the process without formal EAC review was contemplated only in emergent and clear situations, e.g. cardiopulmonary arrest consequent to end stage cardiogenic shock.

IV.
SUBSEQUENT EXPERIENCE WITH FUTILITY CASES

In the year and a half since we implemented this policy (given approval by our EAC, Clinical Executive Board -- all service chiefs -- and Medical Center counsel and administration), numerous cases have been proposed as futile. The first fact about our subsequent experience with this policy is that

we have not yet actually exercised the unilateral abatement of treatment that it authorizes. We came close to this in a number of cases, but never all the way. This may tend to suggest that the policy itself turned out to be futile; however, as the remaining discussion will document, this was not the case. We will provide such documentation with reference to occurrences keyed to each step of the "process".

(1) Perhaps the most significant effect of the policy has been that cases that were once considered "intractable", i.e. where patients and/or families continued to insist on aggressive treatment in the face of extensive contrary counseling by staff, were now identified as potentially "resolvable". Ethics consultations that otherwise were not being requested were now occurring. And frequently, "intractable" disputes between staff and patients and/or families were proving to be otherwise with the injection of new personnel into the scene.

(2) Concurrence by a second attending clinician also tended to rectify a number of cases in one fashion or another. In some cases the futility claim itself was seen as clinically inappropriate. At times this was no more than the result of debunking "poetic" and vague futility claims that amounted to staff feeling treatment was not prudent; that there was no possibility of benefit was not even being claimed, just a low likelihood or low degree of benefit. In other cases, clinician views regarding patient status and prognosis had to be clarified. In a number of instances, this occurred simply because the concurring attending physician chosen was usually a specialist in the relevant clinical area at issue, e.g., a neurologist when persistent vegetative state was being diagnosed. In the end, as we had anticipated, concurring attending consultation was needed to weed out both overly vague and "poetic" formulation of futility, as well as guard against erroneous clinical judgments about its presence. Our experience definitely confirms that this step is essential.

(3) As mentioned, consultation by members of the EAC often resulted in successful dispute mediation where intractable disagreement had seemed to be the case. In practice, this consultation was routinely provided by our Ethics Consultation Team, a rapid response, 24 hour coverage bedside consultation service. Some staff had long been taking advantage of this service, which gave fresh "outsiders" the chance to repair broken communications. Now many others routinely requested such assistance, in part because of its record of success. Many "futile" cases were thus turned into cases where further management was agreed to by all parties.

(4) Assessment by members of the Ethics Consultation Team often led to removal of some cases from the process that led to unilateral withdrawal. This assessment was keyed not only to family counseling but also to a search for possible prior statements by the patient that had not previously been identified. Often such statements were unearthed by asking if other family members had recently died, and what the patient may have said about this at the time. Somewhat to our surprise, many of these patients had, in fact, made sufficiently clear prior statements to direct further management away from aggressive care. In many cases, this was accomplished simply by unearthing and then discussing such statements with the family members. In a few cases, even though the families continued to insist on aggressive treatment regardless of the prior statements, we still proceeded to honor the reported prior statements as legally binding on ourselves and on the family. But these cases were not authorized under our medical futility policy. Rather, they were justified under the patient autonomy provisions of our "limitations of treatment" policy.

(5) Finally, given the nature of futile situations, a number of cases were "resolved" simply because the patient died before the process could be completed. Also, at various points, the process was stopped because the attending physician was unwilling to take such a confrontational position vis-a-vis the family. In some cases this occurred simply because the attending did not want to risk the court battle that we advised them might well ensue if we proceeded. In other cases, as already noted, the process was stopped because, although the patient was arguably in a futile situation, it was not felt to be "worth it" or "appropriate" to continue. In the "immanently dying, beyond suffering" patient, it was not usually felt to be worth the effort (and confrontation), to proceed if all that would be abated was CPR. Equally, it was not felt to be appropriate to confront families with a futility judgment if they had not been given a decent chance to make up their own minds about what was to be done. In part the judgment here turned on what it was "costing" the patient in terms of indignity and, particularly, suffering while the family was given further counseling and/or the opportunity to sort things out or grieve.

V.
CONCLUDING REMARKS

Even though we have not yet actually exercised the unilateral abatement that our futility policy authorizes, numerous benefits have clearly resulted from its institution. A whole class of patients have been earmarked for further consultative response where once their cases were considered intractable and simply (albeit grudgingly) accepted. Many of these cases have subsequently been resolved in much more agreeable fashions to all concerned parties. Beyond this, further discussion and reflection on the proper response to such cases has occurred within our medical center. In effect, we now have what amounts to a detailed clinical protocol regarding proper response to and management of such troubling cases. And thus we can, as we have done here, offer it to our clinical colleagues elsewhere, for their use as well as their comments.(1)

REFERENCE

1. A longer, more wide-ranging discussion of the problem of medical futility, with some reference to the material offered here, has been published elsewhere by two members of our ethics advisory committee. See: **Stephen Wear and Gerald Logue, "The Problem of Medically Futile Treatment: Falling Back on a Preventive Ethics Approach", The Journal of Clinical Ethics, Vol. 6, No. 2 (Summer 1995), pp. 138-48.**

Futility and Its Uses

by Bradley E. Wilson, Ph.D.,
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An elderly patient with metastatic cancer has been hospitalized and his condition is deteriorating. If he were to suffer a cardiac arrest, should he be given CPR or would such treatment be futile?

The word 'futility' is being heard more and more frequently in the hospital and in the ethics community. While the idea that treatment in certain cases might be futile has a long history, going back at least to the ancient Greeks, its recent prominence raises some important questions about contemporary medicine and medical ethics. At the most general level, the main questions are: What is futile treatment and what role should futility judgments play in clinical decision-making? I will suggest an answer to the first question that leads to the conclusion that futility judgments should play, at best, a very limited role in clinical decision-making.

In order to consider the role of futility judgments in clinical medicine, it would be nice if there were a generally agreed upon definition of 'futility' and 'futile treatment'. Unfortunately, there is no consensus about this. Before considering the alternatives, and deciding which is most appropriate, it is helpful to see how physicians and ethicists have proposed to make use of futility judgments.
There are two main uses to which futility judgments are commonly put. First, a physician might rely on a judgment of futility to justify not offering a particular treatment as an option to a patient or their surrogate.[1] For example, for an elderly patient suffering from multi-organ failure, CPR might be deemed to be futile, and thus would not be presented as an option to the patient's decision-maker. Secondly, a physician might override the expressed wishes of a patient or their surrogate for treatment, on the grounds that the desired treatment is futile.[2] Here, CPR might be withheld in situations where it was determined to be futile, even if the patient and/or their surrogate had indicated that they want it to be provided. In either case, the judgment of futility provides the basis for making a decision about whether or not to offer or provide a form of treatment to the patient.

Identifying these two possible uses of futility judgments highlights an important ethical dimension of the issue. Given the value typically placed on patient autonomy and shared decision-making, it is clear that these uses of futility judgments are, at least potentially, ethically problematic. Not presenting a particular treatment as an option, or overriding the expressed interests of the patient or surrogate, are acts that require justification. In a sense, the notion of futility is supposed to provide that justification: if treatment is futile, then the physician has a good reason for doing what he or she does. In thinking about how best to understand futility, we need to be aware of its potential role in providing an ethical justification for certain types of clinical decisions.

When is treatment futile? As it stands, this question cannot be answered. First, we need to identify the particular goals of treatment: futility can be judged only with respect to some specific goal or goals of treatment.[3] Often, disagreements about whether or not a particular treatment is futile are actually disagreements about the goals of treatment, not about futility. Whether or not CPR for an elderly patient is considered futile depends on whether the goal is eventual discharge from the hospital or just maintaining life long enough for a final visit from distant family members.

Once the goal of treatment has been identified, there are two plausible ways of understanding what it means for treatment to be futile. First, treatment might be judged futile if there is a very low probability of achieving the goal of treatment under the circumstances. The very low success rate of CPR in elderly patients with serious underlying illnesses has been used to support the claim that such treatment among those groups is futile and need not be offered.[4]

The second way of understanding futility is in terms of no possibility of achieving the goal of treatment, rather than a low probability. This notion is sometimes referred to as "physiologic futility". It applies in far fewer circumstances than the preceding notion, since it is a rare situation in medicine where there is no uncertainty about the outcome. Nevertheless, there are situations in which this notion of futility would apply, such as the use of CPR where a cardiac rupture makes restoring cardiac function impossible.[5]

Which way of understanding futility is more appropriate, given the previously described roles of futility judgments in clinical medicine? While the first is probably closer to the thinking of many people, we need to recall the ethical role that futility judgments play. Is a physician justified in overriding a patient's or surrogate's expressed interest on the grounds that there is a low likelihood of achieving the desired outcome? Whether or not a low likelihood of achieving an outcome is unacceptably low can only be determined by reference to the patient's values. Using the probabilistic notion of futility, it would be possible to ignore the patient's values, since that notion relies on the physician's determination of when the likelihood of achieving the desired outcome is too low. The second characterization of futility, in terms of no possibility of achieving the outcome, would not have this problem: if there is no possibility of benefit, there is no need to make a burden/benefit assessment. Thus, if we take seriously the role of futility judgments as providing a

moral justification of certain kinds of clinical decisions, we should adopt the narrower, more restricted interpretation of futility.

One issue that has not been addressed here is the issue of the cost of medical care. The reason for this is that cost has nothing to do with the issue of futility: futility has to do with the possibility of achieving medical goals, not the cost of doing so. Effective treatment can be very expensive; futile treatment can be very cheap. Cost considerations may be relevant to medical decision-making, but they should not be addressed under the guise of futility.

References

[1] Tomlinson T, Brody H. Futility and the ethics of resuscitation. JAMA. 1990; 264: 1276-1280.

[2] Schneiderman LJ, Jecker NS, Jonsen AR. Medical futility: its meaning and ethical implications. Annals of Internal Medicine. 1990; 112: 949-954.

[3] Truog RD, Brett AS, Frader J. The problem with futility. NEJM. 1992; 326: 1560-1564.

[4] Blackhall LJ. Must we always use CPR? NEJM. 1987; 317: 1281-1284.

[5] Truog, Brett and Frader.

Truly Useful Literature:

Focus on Futility

by Alan Joyce, B.A.

Medical Futility: Its Meaning and Ethical Implications
Scneiderman, LJ; Jecker, NS; Jonsen, AR.
Annals of Internal Medicine. 1990; 112:949-954

In this article, the authors attempt to provide a working definition of medical futility, with a strong bias towards giving physicians power to make futility judgments. Their first step towards this definition involves a comparison of effect and benefit, revolving around the proposal that futile treatments are those which fail to provide a *benefit* to a patient (in terms of comfort, well-being, general health, etc.) even though they may produce a measurable *effect*. They further narrow their definition by distinguishing futility from related terms like *impossible*, *implausible* (theoretically possible but unreasonably complex), *uncommon*, and *hopeless* (which describes a subjective, not objective state).

Following these distinctions, quantitative and qualitative criteria are introduced in an attempt to provide guidelines for physicians' determination of futility. The authors propose that if in 100 consecutive previous cases a treatment is seen to be futile, then sufficient quantitative evidence exists to declare that treatment futile in a current case. The authors also propose that with several notable exceptions (which are based on compassion rather than benefit), a patient has no right to be sustained in a vegetative state, or in a condition requiring constant monitoring or life support.

Futility and the Ethics of Resuscitation
Tomlinson, T; Brody H
JAMA. 1990; 264:1276-1280

Tomlinson and Brody also advocate physician authority over futility judgments, but suggest that this authority should be derived from an ongoing social dialogue. They claim that "Thorough discussions with individual patients, semipublic discussions...and broad public education are all needed to evolve a socially shared understanding of what counts as a 'reasonable' chance for a 'worthwhile' benefit relative to an 'acceptable' risk of harm." The model they propose moves the discussion of futility out of the consent process and into a more public forum.

Futility and Hospital Policy
Tomlinson, T; Czlonka D
Hastings Center Report. 1995; 25(3): 28-35

Tomlinson and Czlonka review practical considerations in creating a formal futility policy, and present their own model policy (which is very similar to the policy described by Wear et al. in this issue of *Community Ethics)*. This policy states that resuscitation will be attempted unless (1) a patient is brain dead (and declared legally dead), (2) the patient has a DNR order, or (3) a determination is made that resuscitation would be futile or harmful. The process for making this determination builds upon the definitions presented in Tomlinson's previous work, and includes guidelines for (1) confirmation of futility judgments, (2) disclosure of futility judgments to patients or patient representatives, and (3) provisions in case a patient disagrees with said judgments, or in case an incompetent patient has no representative. This policy also provides for some legal protection for physicians and nursing staff who do not resuscitate a patient whose DNR order is a result of the above guidelines.

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There is an *enormous* body of literature on this topic, and very little space to address it here. A few further reading suggestions are: Stuart Youngner's article, **"Who Defines Futility?"** (JAMA, 1988; 260(14): 2094-95) which responds directly to proponents of policies which allow for absolute physician authority regarding futility judgments. Youngner says that in most cases, frank communication with patients and families will result in their agreement with futility judgments. He argues against claims that unilateral DNR decisions will "save time" and allow physicians to spend more time discussing other plans; this position, says Youngner, will "provide a justification for having physicians make unilateral and secret decisions about other 'useless' therapies." Also recommended are: Steven Miles' **"Medical Futility,"** (Law, Medicine, & Health Care. 1992; 20(4):310-15) which analyzes futility as (a) a logical ideal, (b) a professional duty, and (c) an institution; and Schneiderman and Jecker's book, ***Wrong Medicine***. (Johns Hopkins University Press. Baltimore, MD, 1995) This work includes chapters on "Families Who Want Everything Done," "Futility and Rationing," and "Medical Futility in a Litigious Society."

Retreat Highlight: Managed Care

On September 29, 30, and October 1, 1995, the Consortium Ethics Program held its Fifth Annual Ethics Retreat. The retreat provides an opportunity to introduce topics that will be covered in greater depth in the seminar classes and for the hospital representatives to build community among themselves and with the faculty.

This retreat was by far the most successful to date. Over 120 representatives of the member hospitals, as well as a few individual members, gathered together. The retreat had two parallel tracks: new members heard talks on basic topics in medical ethics while those who have been through several years of CEP training heard talks that highlighted the contributions of history, literature, film, psychology, and philosophy to medical ethics.

Because ethical issues related to managed care are a pressing concern to all healthcare professionals, regardless of their level of training in ethics, a session on this topic was part of the program for both tiers. For your edification, we reprint excerpts from these talks which were given by a philosopher and an attorney.

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Ethical Issues in Managed Care

by Mark R. Wicclair, Ph.D., Professor of Philosophy, West Virginia University; Associate, University of Pittsburgh Center for Medical Ethics.

Managed care comes in a variety of shapes and sizes. However, instead of reviewing the distinguishing features of each type of managed care arrangement, I will focus on common characteristics and general ethical themes and issues.

It is helpful to think of managed care in terms of a continuum, with health maintenance organizations (HMOs) at one end, indemnity plans that employ measures such as pre-certification, case management and utilization review at the other end, with preferred provider organizations (PPOs) somewhere in between. What places these various arrangements on the same continuum is that each represents an effort to integrate and control the financing and delivery of healthcare. Integrating and controlling the financing and delivery of healthcare might be termed the basic principle of managed care, and its primary objective is cost containment. Managed care arrangements utilize a variety of strategies to accomplish this objective, and their potential impact on physicians and patients within managed care plans and organizations merits careful ethical scrutiny.

However, before looking at managed care organizations from the inside, let's take a quick look at the "big picture" from the outside. Not too long ago, there was a lot of talk of a "crisis" in healthcare. It may be hard to believe it now, but less than two years ago, there seemed to be agreement among Democrats and Republicans on this point. The perceived crisis had two components: One was a crisis in cost and spending; the other was a crisis in access. Managed care is designed to address the first component of the crisis. According to some reports, it appears to be having some success in reducing healthcare costs and spending. However, it is questionable whether managed care alone will successfully address the second component of the crisis.

Recent data indicate that the number of uninsured Americans is still increasing, and is now greater than 43 million. Moreover, there are reasons to worry that managed care in an unregulated free market environment may aggravate the situation. One example is the so-called "cherry picking," whereby managed care plans attempt to enroll healthier people and exclude those who are not healthy. This suggests that even if managed care in an unregulated free market environment can bring down healthcare costs, it may not adequately address the issue of fair access. Before we consider some ethical issues and questions associated with managed care from the "inside," let's consider an additional question from the outside.

The question I have in mind is: How will managed care affect people's ability to choose their health plans and physicians? A large percentage of Americans with private insurance get it through their employers. Employers often do not offer employees much choice. In an unregulated free market environment, the search for the least costly plan may lead to still fewer choices. It may also result in frequent changes in plans offered by employers. Ironically, one of the primary criticisms of the ill-fated "Clinton plan" was the lack of choice. Moreover, when employers are offered choices, it is questionable that informed choice is feasible at the time of entry.

Now let's take a look at some ethical questions and issues from the "inside" (i.e., from the perspective of physicians and patients within managed care plans). One important question is: What is the impact on quality of care? Preventive care may increase, but patients are likely to get fewer tests and medical interventions. Is more always better, or is less sometimes better in terms of patient health? If less is sometimes better, do managed care arrangements promote decision-making that eliminate tests and interventions that are unnecessary from the perspective of patient health? That is, do any types of managed care arrangements achieve a proper balance

between "overtreatment" or "overutilization," on the one hand, and "undertreatment" or "underutilization," on the other? Currently, there is little data that would allow an evaluation of quality of care. But there are efforts under way to develop reliable measures of quality and to gather relevant data.

Another important question is: How will managed care affect the physician-patient relationship? Traditionally, this relationship has been viewed as a fiduciary relationship in which the physician owes the patient a duty of loyalty, an obligation to place the patient's interests first. Corresponding to physician loyalty is patient trust. This fiduciary model is based upon assumptions such as the following: (1) physicians have significantly more power than patients, (2) patients are vulnerable because of their illness and lack of expertise and knowledge, and (3) physicians have a virtual monopoly over the dispensing of most medical therapies.

Taken literally, the fiduciary model is sheer fantasy. For one thing, physicians cannot be single-mindedly devoted to each patient and give each patient unlimited time, attention, and care. The only way to satisfy this requirement would be for a physician to have no more than one patient at a time. In addition, it is often necessary to decide which patients will get limited resources (such as ICU beds, ECMO, and organs). Further, financial conflicts of interest under fee-for-service have been well documented and are one reason why managed care is seen as an appealing alternative. Thus, the fiduciary model fails to correspond to reality and seems unacceptable as an ideal. But, what should replace the fiduciary model and its notion of undivided loyalty to patients? Undivided loyalty to the managed care organization? Do physicians in managed care organizations any longer have a duty to act as patient advocates?

Managed care systems commonly make use of primary care physicians as gatekeepers who decide whether or not to refer patients to specialists. In carrying out this gatekeeping function under managed care, physicians are expected to consider factors other than expected benefit to the particular patient. Specifically, they are also expected to consider cost. Is this type of gatekeeping function appropriate for physicians?

Some managed care organizations offer financial incentives to physicians to reduce services (e.g., salary increases and bonuses). When such financial inducements are offered, the ideal of physician decisionmaking that is not influenced by personal financial gain is abandoned. Rather than being discouraged from considering their own financial interests, physicians are encouraged to do so. That is the point of financial incentives.

Such arrangements raise several concerns: **(a) What will the impact of these arrangements on patient trust? (b) What will be the impact on the quality of care? (c) Even if adverse consequences do not result, isn't there a lack of "propriety" in doctors' decisions being influenced by their financial interests?** Ethical concerns about the use of financial inducements to limit services have led some commentators to endorse other alternatives. One alternative is to impose more or less rigid practice guidelines and to remove physician discretion (no "bedside rationing"). A major problem with this alternative is its unfeasibility and/or undesirability. Flexibility/discretion may be essential to the practice of medicine. Another alternative is global budgets, such as those used in England. Cost is taken into account, but not via the physician's financial interests.

Another question is: To what extent are managed care arrangements compatible with shared decisionmaking? In many clinical contexts there is no one "right decision" because it is necessary to balance benefits and burdens and the "right" decision is in part a function of the patient's distinctive preferences and values. This suggests that decision-making should be a shared or collaborative activity between physicians and patients. Managed care appears to pose a significant challenge or obstacle to shared decision-making as the patient's values and preferences may carry less weight than other practice considerations.

Another set of questions relates to informed consent. How should informed consent be implemented within managed care organizations? Do physicians have an obligation to inform patients of treatment options that are not covered by the particular plan? And if so, is it sufficient to present these alternatives neutrally, or is there an obligation to inform patients when it is thought that an uncovered option is (far) superior?

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Managed Care:

Practical Coping for Healthcare Providers

By Andrew E. Thurman, Esq., Senior Vice President and General Counsel, Forbes Health System

Many assert that managed care, with its inherent inducement to withhold services, is unethical. If healthcare is considered a commodity, then such an assertion is probably inaccurate. But if a certain level of basic healthcare is (or should be) a right, as most healthcare providers seem to believe, then any reimbursement system which encourages either the underutilization or overutilization of resources, such as capitation or fee-for-service, respectively, is unethical.

Because managed care is a reality, providers must learn to deal with its unethical reimbursement policies.

Consider the following case:

A patient is medically ready for discharge but, has no support at home until the next day. Consequently, the physician orders an additional hospital day before discharge, for which the payer refuses to pay the hospital because it is medically unnecessary.

As managed care spreads, providers will find innovative alternatives, such as home care, to resolve this scenario. But until that happens, the hospital should not "eat" this loss — it should be the responsibility of the patient or the ordering physician. But if the payer refuses to reimburse the hospital for a day's stay that the physician and the hospital believe is medically necessary, the hospital should pursue all legal remedies against the payer. Even though such a strategy is not effective on a case-by-case basis, experience has shown that this strategy can alter the behavior of the payer over the long term.

In sum, the challenge of managed care to providers is to determine, and aggressively enforce, who should bear the cost of services provided. If the services are medically necessary, the payer should pay. If the services are not medically necessary, then the patient or the responsible (usually the ordering) provider should bear the cost. For example:

A post-surgical patient needed blood prior to discharge. Although the blood was readily available and discharge could have occurred soon after administration, the patient insisted on donor-directed blood, which would result in prolonging the hospital stay three days. After considerable discussion, the patient was offered the choice of accepting the available blood, paying for the additional stay, or being discharged "against medical advice" and returning for donor-directed blood, when available, as an outpatient. This last option, obviously involved some additional risk to the patient. Nevertheless, the patient chose this riskier course, which was accomplished without incident.

In this case, the patient chose to assume the risk. In other cases, providers hope that managed care payers will receive liability risk when they deny authorization for medically necessary care. However, a review of the law leads to the clear conclusion that providers will always have liability risk when they choose not to provide services because authorization for those services has been denied. The proper course for providers when they believe services are medically necessary is to provide those services and then aggressively pursue the payer for payment.

Upcoming National Events

February 29-March 2, 1996.
Fifth Annual Meeting of the Association for Practical and Professional Ethics. To be held at the Stouffer Renaissance Hotel in St. Louis, MO. Deadline for advance registration is January 15, 1996. For information about the conference and the "call for papers," contact: Association for Practical and Professional Ethics, 410 North Park Avenue, Bloomington, IN 47405. Phone: 812-855-6450; FAX: 812-855-3315. E-mail: APPE@INDIANA.EDU

April 18-19, 1996.
"Protecting the Vulnerable: Public Policy and Human Experimentation." Sponsored by the Center for Bioethics at the University of Pennsylvania. For information, contact: Jonathan Moreno, Ph.D. at 215-898-7136.

May 17, 1996.
"Ethics Consultation 1996: The State of the Art." A regional conference sponsored by the Society for Bioethics Consultation, Robert C. Byrd Health Sciences Center, West Virginia University, Morgantown, WV. For information, contact Cindy Jamison at (304) 293-7618 or FAX: (304) 293-7442

June 9-12, 1996.
"Genomic Information: Ethical Implications." University of Washington, Seattle, WA. This intensive advanced course will emphasize principles and methods that both scientists and ethicists can use to study and resolve ethical issues related to the Human Genome Program. For further information, contact: Marilyn J. Barnard, Program Coordinator; Medical History & Ethics; Box 357120; University of Washington, School of Medicine, Seattle, WA 981995-7120. Phone: (206) 616-1864, FAX: (206) 685-7515. Email: <mbarnard@u.washington.edu>

Congratulations!

We congratulate Bob Arnold, M.D., Associate Professor of Medicine and Associate Director for Education at the University of Pittsburgh Center for Medical Ethics. **Bob is the new President-Elect of the Society for Health and Human Values.**

Upcoming CEP Events

Consortium Ethics Program
Series One Classes

Tuesday, March 5, 1996
1:00 pm - 5:00 pm
"Surrogate Decision Making, Advance Directives, & DNR Orders"
Rosa Lynn Pinkus, Ph.D. and Alan Steinberg, Esquire

Tuesday, April 2, 1996
9:00 am - 12:00 pm
"Death and The Ethics Committee: Stopping, Starting, and Getting Out Alive"
George Annas, J.D.
Boston University

Friday, May 3, 1996.
1:00 pm - 5:00 pm
"Ethical Theory/ Models of the Physician-Patient Relationship"
Mark Kuczewski **(Make-up class)**

Thursday, June 6, 1996
1:00 pm - 5:00 pm
"Forgoing Life-Sustaining Treatment: Politics, Ethics and the JCAHO"
Mark Wicclair, Ph.D.

Consortium Ethics Program
Series Two Classes

Tuesday, March 5, 1996
9:00 am - 12:00 pm
"Ethical Issues in Rehab: Lessons for the Acute Care Hospital"
Giles Scofield, J.D.
Pace University

Tuesday, April 2, 1996
1:00 pm - 5:00 pm
"Life, Liberty, and The Pursuit of Death: American Culture and Choice at the End of Life"
George Annas, J.D.
Boston University
(This session will be held at the University of Pittsburgh)

Friday, May 3, 1996
9:00 am - 12:00 pm
"Ways of Thinking: Psychology and Moral Development"
Jyotsna Vasudev, Ph.D. **(new class)**

Thursday, June 6, 1996
9:00 am - 12:00 pm
"History of Genetics: The Black Stork"
Martin Pernick, Ph.D.
University of Michigan

Optional for both groups:

Wednesday, May 8, 1996
8:00 am - 5:00 pm
Duquesne Conference, *"The Ethics of Managed Care"*
(This conference will be held at Duquesne University)

* All CEP classes, **unless other wise indicated,** are held at the Education Center of the Hospital Council of Western Pennsylvania, Warrendale, PA.

Ethics for Lunch

Spring 1996 Schedule

AUDITORIUM 5, SCAIFE HALL,NOON - 1:00 P.M.

January 25, 1996
Pregnant Men: A Feminist Perspective on the Disposition of Frozen Embryos After Divorce
Ruth Colker, J.D.
Professor Of Law
University of Pittsburgh

February 8, 1996
Unwitting Participants? Research Subjects: What They Think and How We Protect Them
Jeffrey Kahn, Ph.D., M.P.H.
Assistant Professor of Bioethics
Medical College of Wisconsin

February 22, 1996
Sirens of Utility: The Odyssey of Managed Emergency Care
Gregory Larkin, M.D., M.S.P.H.
Assistant Professor of Medicine
University of Pittsburgh

March 14, 1996
Should Scientific Societies Enforce Their Codes of Professional Ethics?
William P. Gardner, Ph.D.
Associate Professor of Psychiatry
University of Pittsburgh

March 28, 1996
Giving the Breath of Life: Lessons from Live Lung Lobe Donation and Transplantation
Rachel Ankeny Majeske
Ethics Research Associate
Center for Medical Ethics
University of Pittsburgh

April 12, 1996
Discussions about Advance Directives: Doctor-Patient Dialogues
Gary S. Fischer, M.D.
Assistant Professor of Medicine
University of Pittsburgh

The Center for Continuing Education in the Health Sciences, University of Pittsburgh, is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. The Center for Continuing Education in the Health Sciences designates this continuing medical education activity for 1 credit hour in Category 1 of the Physician's Recognition Award of the American Medical Association. Nurses and other healthcare professionals are awarded 0.1 continuing education units (CEUs).

Sponsored by the Center for Medical Ethics and the Center for Continuing Education in the Health Sciences, University of Pittsburgh

The Consortium Ethics Program On-Line!

You can reach the CEP's World Wide Web Site at
http://www.pitt.edu/~caj3/CEP.html

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Mark Kuczewski, Ph.D., Associate Director & Editor of *Community Ethics*
Anne Medsger, R.N., M.S., Evaluation Consultant
Jody Chidester, Administrative Assistant
Alan Joyce, Editorial Assistant

We also extend a special word of thanks to the Vira I. Heinz Endowment for its continued support of the Consortium Ethics Program and to the Ethics Task Force of the Hospital Council of Western Pennsylvania for the continued encouragement, guidance, and assistance that it lends to the CEP.

If you have any suggestions or questions regarding the Consortium Ethics Program, wish to submit information for an upcoming edition of *Community Ethics* or would like to receive this newsletter, contact:
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