"The object of philosophy is the logical clarification of thoughts. Philosophy is not a theory but an activity."

— *Ludwig Wittgenstein*

Hot Topic

Futility: Responding to Requests for Non-Beneficial Treatments

The idea of futility of treatments is an underlying theme in many ethically challenging clinical situations. How do we address and create a policy for these cases? The necessity of futile care policies is understandable, but they need to be fair, reasoned and ethically sound.

An establishing understanding is first regarding the power of language and words. The language that we use matters; the specific words that we use matter. This is especially true in the clinical environment and when communicating with families. There are strong arguments for moving away from the term *futile* and *futility* and instead using terms *non-beneficial* and *medically inappropriate. U*sing these terms instead of *futile* allows for more appropriate understanding of the clinical situation, while continuing to respect the medical preferences of the patient. It also avoids the need to establish a universally accepted definition of the word *futile*, which is extremely challenging to do. There is, among others, qualitative futility, objective futility, and qualitative futility. Meaning, futility may refer to the quality of life a treatment would produce, an expression that is more quasi-numeric, or the improbability of an event happening ([Schneiderman, 1990, p. 951](#)).

Standards and Best Practices

An important first step prior to implementing a non-beneficial treatment policy is to understand standards and best practices used by others. Many hospital and health systems utilize those described in an article by [Bosslet et al. (2015](#)), *An Official ATS/AACN/ACCP/ESICM/SCCM Policy Statement: Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units.*

This policy statement is a comprehensive overview of the difficulties regarding non-beneficial treatment and communicating these issues with patients and their families. It also introduces recommendations and steps for addressing them. These steps and recommendations have been adopted by many hospital organization and become the establishing premise of non-beneficial treatment policies. The policy statement is informative and humble, with a sense of understanding of the gravity of the situations and recommendations. The policy statement begins by directly addressing the difficulty of these situations, stating, "One of the most ethically controversial issues in intensive care units (ICUs) is how to respond to requests from surrogates to administer life-prolonging interventions when clinicians believe those interventions should not be administered" ([Bosslet et al., 2015, p. 1319](#)).

Recommended Steps

The policy statement has specific steps (i.e., an algorithm) for addressing these types of clinical situations, described as "Recommended Steps for Resolution of Conflict Regarding Potentially Inappropriate Treatments." They are:

> *1. Before initiation of and throughout the formal conflict-resolution procedure, clinicians should enlist expert consultation to aid in achieving a negotiated agreement.*

> *2. Surrogate(s) should be given clear notification in writing regarding the initiation of the formal conflict-resolution procedure and the steps and timeline to be expected in this process.*

3. Clinicians should obtain a second medical opinion to verify the prognosis and the judgment that the requested treatment is inappropriate.

4. There should be case review by an interdisciplinary institutional committee.

5. If the committee agrees with the clinicians, then clinicians should offer the option to seek a willing provider at another institution and should facilitate this process.

6. If the committee agrees with the clinicians and no willing provider can be found, surrogate(s) should be informed of their right to seek case review by an independent appeals body.

7a. If the committee or appellate body agrees with the patient or surrogate's request for life-prolonging treatment, clinicians should provide these treatments or transfer the patient to a willing provider.

7b. If the committee agrees with the clinicians' judgment, no willing provider can be found, and the surrogate does not seek independent appeal or the appeal affirms the clinicians' position, clinicians may withhold or withdraw the contested treatments and should provide high-quality palliative care. [(p. 1325)](.)

Balancing Benefit and Harm

These are effective and fair steps, prioritizing respect for the patient while also addressing the fact that some interventions and treatments reach a point that they become no longer medically feasible. And if they are not medically feasible, they are a violation of the principle of nonmaleficence.

All medical treatments come with some level of risk and harm, even minor ones. Often times, the benefits of the treatment easily outweigh the risks and harm, thereby making the treatment recommended. But if there is no benefit, then there is only harm. These are challenging patient situations that need to be handled with care and respect. But the obligation to avoid unnecessary harm remains. Having a fair and openly transparent procedure model for addressing these clinical situations is important. *An Official ATS/AACN/ACCP/ESICM/SCCM Policy Statement* is one of the better starting points.

Bioethics in the News

[Pro-life doctor weighs in amid furor over Ohio ectopic pregnancy bill](.)

[Journal of Health and Human Experience](.)

[A CT scan costs $1,100 in the US — and $140 in Holland](.)

[Bioethics experts call on GoFundMe to ban unproven medical treatments](.)

[Genome-edited babies may be justifiable says bioethicist](.)

[What clinical ethics can learn from decision science](.)

Case Study

The patient, Mrs. Czarniwicz, is a 67-year-old female diagnosed with non-resectable colon cancer six months ago. She was recently admitted for sepsis. The patient is additionally suffering from acute shortness of breath (potentially congestive heart failure or pulmonary embolism) and an acute GI bleed.

The patient is intubated and in poor condition, with generalized edema and skin excoriation. The patient retains only gross motor movement of upper extremities, communicating mainly by head movements. Based upon discussions, the patient's code status was Full Code, with patient requesting resuscitation if needed. Mrs. Czarniwicz currently does not have capacity, with daughter (Jane) acting surrogate decision-maker, and who is requesting "everything be done." This appears to be consistent with the goals of care expressed by Mrs. Czarniwicz, who continues to remain of vasopressors, although pressure continues to drop (30-40 systolic). The medical team is concerned moving forward, believing that continuing aggressive measures may be futile as she continues to worsen, becoming anuric, developing massive generalized edema, and oozing fluid from skin.

Case provided from University of Loyola Chicago Bioethics department.

https://hsd.luc.edu/bioethics/

Ethical Musings

What does it mean to have the obligation to do good? One of the fundamental principles of bioethics is the principle of beneficence, or the moral obligation to act for the benefit of other (Beauchamp & Childress, 2013, p. 203). But what does it mean to have this obligation? How much benefit can one be expected to be obligated to do? And for that matter, what does "good" even entail?

Ought Implies Can

Immanuel Kant famously argued that *ought implies can.* This is concept holds that for one to be morally obligated, one must be first capable of fulfilling that obligation. It would be ridiculous for me to have a moral obligation to gift everyone I know one million dollars because I am not financially capable to do so. That does not mean doing so would not be good or beneficial, or even able to be described with the word *should. R*ather, I cannot be expected to have an obligation to do something I am not able to. So to understand the reverse, if I do have an obligation, by nature of just having that obligation it is assumed that I am capable to fulfilling that obligation. *Ought implies can.*

Therefore, for the provider to have the obligation to do good, it can only be expected that she or he is capable of doing so. This defines the difference between obligatory beneficence and ideal beneficence. Obligatory beneficence is the moral requirement of particularly actions while ideal beneficence is the acknowledgment of the benefit of the action. While I may not have the moral obligation to give one million dollars to everyone I know, it would be morally beneficial if I did so. Therefore, "we are not morally required to perform all possible acts of generosity or charity that would benefit others. Much beneficent conduct therefore does constitute ideal, rather than obligatory, conduct, and the line between an obligation of beneficence and a moral ideal of beneficence is often unclear" (B&C, p. 204).

This demonstrates the difficulty with *ought* statements.

Prescriptive vs. Descriptive

R.M. Hare explores *ought* statements in his work on the difference between prescriptive and descriptive meaning. Essentially, prescriptive meaning are statements that entail an imperative or prescribe an action. Descriptive meanings are descriptive to the "extent that factual conditions for its correct application define its meaning" (Stanford Encyclopedia of Philosophy). Ethical or moral statements have both: prescriptive and descriptive meaning.

For example, the statement "*A* [a person] ought to φ". This statement contains the the imperative "Let *A* φ", which implies that it is socially acceptable for A to do φ. That is a prescriptive statement that can then create descriptive

statements. Such as, if we desire for A to do φ, that could mean that φ is beneficial or enjoyable, which is descriptive. Therefore, the imperative prescriptive statement "*A* ought to φ" may create the descriptive implication of "φ-ing is beneficial or enjoyable" (SEP).

But Hare never says that all ethical statements are imperatives. He also addresses that *ought* does not imply *will*. To state, "I ought to φ" does not entail "I will φ", an idea that has been around in philosophy to at least Socrates and Plato. To use the example from earlier, even if, hypothetically, I ought to give a million dollars away, that does not mean I will give a million dollars away.

Non-Beneficial Treatment Implies Cannot

Applying these ideas to medicine, we ought to do what we can as providers to help our patients. The level of that obligation comes down to the abilities of the individual provider (arguably obligatory beneficence), but going beyond that obligation moves into ideal beneficence. Doing what is medically possible to benefit patient is obligatory beneficence; donating a majority of your salary to others can be ideal beneficence. And specifically, non-beneficial treatments -- if a patient's condition reaches the point that medicine would not have a benefit to the patient -- fundamentally changes the ought statements we typically adhere to. *Ought implies can,* and non-beneficial treatment implies cannot. Therefore, the ought statement becomes irrelevant. We must first establish what we can do. Then we can move forward to understand what we ought to do.