

Guidelines on Resolving Conflicts About Treatment Deemed “Futile”

From time to time the Catholic Medical Association (CMA) is asked to intervene in cases in which a physician or health care facility has made and is enforcing a judgment of medical futility, consistent with an internal policy and/or state law, over the objections of a patient and/or family member(s). As an organization, CMA cannot intervene in particular cases due to their complexity and due to lack of any authority. The CMA can, however, offer guidelines to assist people in working through such issues in a timely, ethical, and charitable manner.

1. The Problematic Nature of Futility Judgments and Policies

Beginning in the 1990s, the concept of medical “futility” was advanced in the medical and bioethics literature in connection with cases in which patients or family members insisted on treatment over the objections of physicians and/or health care institutions. Over the next ten years, a variety of definitions and categories (e.g., quantitative and qualitative) of “futility” were proposed; none achieved widespread support. Rather, there was general agreement that consensus on definitions and on individual cases was unlikely, if not impossible. Moreover, there has been widespread agreement that the development and implementation of futility policies is fraught with dangers – that conflicts between patients/families and physicians/hospitals are best avoided in the first place or addressed in a non-confrontational manner once they arise. Nevertheless, futility policies have been adopted in several cities and states that rely on procedural grounds rather than widely accepted definitions of “futility.” These policies permit unilateral decisions by physicians/hospitals to withdraw medical treatment deemed to be “futile.”

The CMA does not endorse the concept of “medical futility” or recommend the adoption of futility policies. However, the potential for conflict about treatment decisions exists. Sometimes individuals (patients or surrogates) demand treatments that physicians and/or health care institutions consider inappropriate. It is important that Catholic individuals and institutions draw upon sound ethical criteria in addressing such conflicts when they arise and resolve them in a way that properly respects the sanctity of human life and the demands of conscience for all concerned.

2. A Catholic Framework for Addressing Claims of Inappropriate Treatment

A Catholic framework for addressing conflicts in treatment decisions should draw upon the authoritative teachings of the Church. While not explicitly addressing the issue of conflicts between patients and health care providers about whether certain medical interventions are warranted, the *Declaration on Euthanasia* (CDF 1980) (“DOE”) is the best resource for addressing conflict because it delineates more clearly than any other single document the principles that patients and health care providers should be aware of and respect.

A. General Principles

First, the DOE explicitly affirms and explains the traditional Christian rejection of suicide and euthanasia. Even in difficult medical cases, no one is permitted to seek death as an end in itself or as a means to ending suffering. On the other hand, the DOE clearly teaches that the decision to forgo extraordinary treatment (see below) “is not the equivalent of suicide; on the contrary, it should be considered as an acceptance of the human condition, or a wish to avoid the application of a medical procedure disproportionate to the results that can be expected, or a desire not to impose excessive expense on the family or the community.”

Second, the DOE briefly recalls and reaffirms the traditional teaching on ordinary and extraordinary means. People are ethically obligated to use ordinary means to conserve their lives (and the lives of those for whom they are responsible) since human life is a gift of God and a fundamental good. Ordinary means are medicines, treatments and operations that provide some benefit, and/or do not involve excessive burden, pain, or expense.

Extraordinary means are medicines, treatments and operations that do not provide a benefit, and/or involve excessive burden, pain, or expense. While people *may* use extraordinary means, they are not morally obligated to do so since earthly life for humans is not an absolute good and because, at some point, medical interventions are no longer effective and/or because the costs and burdens of medical interventions are out of proportion to the good of earthly life that they are intended to serve. The DOE teaches that no one can impose on a patient the obligation of using an extraordinary means.

B. Conflict Cases

Conflicts can arise when a patient or a surrogate demands a treatment that health care providers find ineffective and/or disproportionate. The patient/surrogate may insist that the treatment is “ordinary” for them, or that, even though the treatment is extraordinary, they are willing to endure it and, hence, should be allowed to receive it. Two other, important considerations in section IV of the DOE can help people to work through such conflicts.

First, the DOE assigns a decisive role to the conscience of the patient or surrogate in accepting or rejecting extraordinary treatments. Thus, the DOE notes that,

“[i]n the final analysis, it pertains to the conscience either of the sick person, or of those qualified to speak in the sick person's name, or of the doctors, to decide, in the light of moral obligations and of the various aspects of the case.”

“If there are no other sufficient remedies, it is permitted, with the patient's consent, to have recourse to the means provided by the most advanced medical techniques . . .”

“It is also permitted, with the patient's consent, to interrupt these means, where the results fall short of expectations.”

That is, as a general rule, it is appropriate for the patient or surrogate to make the final decision on what treatment regimen will be accepted and/or for how long.

Second, the Declaration notes the responsibility of health care providers in general, and of physicians in particular, to provide treatments and interventions that are effective and proportionate. Thus, the Declaration notes that:

health care providers “must do so conscientiously and administer the remedies that seem necessary or useful”; and

“account will have to be taken of the reasonable wishes of the patient and the patient's family, as also of the advice of the doctors who are specially competent in the matter. The latter may in particular judge that the investment in instruments and personnel is disproportionate to the results foreseen; they may also judge that the techniques applied impose on the patient strain or suffering out of proportion with the benefits which he or she may gain from such techniques.” (Emphasis added.)

It is clear from these quotations that physicians and health care providers have an important role to play not only in explaining options to a patient or surrogate but also in judging the propriety of some of these options, particularly when they impose substantial burdens and few, if any, benefits.

While the *Declaration on Euthanasia* delineated these principles, it did not explain how to resolve the impasse that can result from conflicting assessments of the propriety of continued extraordinary treatments. Below are some suggestions.

3. Resolving Disputes

When disputes about treatment arise, all involved must strive to interact in a thoughtful and charitable manner. Everyone involved, patient/surrogate, physicians, and health care institution, should carefully form, and ultimately follow, their conscience. Prayer – shared whenever possible – is indispensable in this process. In addition, both sides should bear in mind, and respect, their responsibilities, for example:

- Responsibilities of patients/surrogates – When patients or surrogates reach an impasse after repeated requests for additional extraordinary treatment, they should:
 - Re-examine their goals or reasons for the treatment and discern whether these goals are reasonable and/or whether there is another way they can achieve them;

- Seek out and prayerfully consider ethical advice from objective, reputable sources;
 - Acknowledge the legitimate role that health care providers play in assessing the propriety of extraordinary treatment;
 - Be open to considering options (e.g., for transfer) even if they are not ideal;
 - Respect the legitimate conscientious beliefs and decisions of their health care providers.
- Responsibilities of health care providers – When health care providers reach an impasse after repeated requests from patients/surrogates for additional extraordinary treatment, they should:
 - Demonstrate compassion in the implementation of futility policy provisions (e.g., where possible and appropriate, extend arbitrary deadlines to allow a patient or surrogate to arrange a transfer);
 - Unilaterally discontinue treatment only as a last resort, after repeated, good-faith attempts to reach resolution;
 - Unilaterally discontinue treatment only where treatment is not only ineffective, but is also imposing such substantial burden or discomfort that the normal allowance given to patient or surrogate consent must be overridden;
 - Make such decisions based on a conscientious conviction that providing continued extraordinary treatment is *wrong*, not based merely on fulfilling the requirements of a law or policy;
 - Never withhold ordinary care;
 - Withhold or withdraw assisted nutrition and hydration (ANH) only as a last resort, within the framework of Pope John Paul II's teaching that ANH "should be considered, in principle, ordinary and proportionate, and as such morally obligatory, insofar as and until it is seen to have attained its proper finality, which in the present case consists in providing nourishment to the patient and alleviation of his suffering."