



# Bioethics Notes

a newsletter from the Bioethics Review & Advisory Committee

January, 2004

"Futility: Hope dies, while pain remains."

Vickilynn Shepard, 2001

## Consult Services

We would like to remind you that the Bioethics Review and Advisory Committee in Danville provides ethics consultation services. We have an alphanumeric pager (2229). Anyone can request an ethics consultation. Page directly by phone, or leave a text message using the Infoweb Phone Directory. Enter "2229" in the Directory Search and then click on the "Quick Page" button.

## Bioethics Committee

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## Case Study

The Bioethics Review and Advisory Committee believes the Geisinger community would benefit from increased communication and educational efforts dealing with current issues in bioethics. Our new [homepage](#) is dedicated to current news in the world of bioethics and is updated on a continuing basis. We also look forward to your participation in our annual ethics conference to be held March 12, 2004 at Susquehanna University on "Ethical Implications of the Medical Liability Crisis." In this issue, we introduce a discussion on futility that includes a simple case study.

Mr. Jones, a 75 year old man with metastatic prostate cancer and Alzheimer's disease has been treated with chemotherapy, radiation therapy and hormonal adjuvants. He has no specific complaints; however, his family is insistent that he receive chemotherapy with a new drug they learned of on the Internet.

In the fifth century B.C., Hippocrates enumerated the roles of physicians "to do away with the sufferings of the sick, to lessen the violence of their diseases, and *to refuse to treat those who are overmastered by their diseases, realizing that in such cases medicine is powerless.*"

In past newsletters, we have noted the guiding principles of bioethics as evolved from the Belmont report: respect for patient autonomy, beneficence, nonmaleficence and distributive justice. We have emphasized the role of patient autonomy, including surrogate decision making, to enable compliance with patient values. Thus, it is well established that a patient can refuse unwanted medical therapy. On the other hand, does the principle of autonomy enforce any limits on requests or demands for medical therapy?

Any course of treatment that confers no beneficial outcome or is medically ineffective and contrary to generally accepted health-care standards may be considered medically futile. It is important to draw the distinction between **medically futile treatment** and futile care. Use of the latter term should be avoided since it implies withdrawal of all types of care to patients. Defining futility in treatment is not the end of care-giving.

Donald Joralemon recently elaborated on these semantics and the practice of futility: whether futility should be restricted or broad in scope, whether it should be patient or physician oriented, whether it should be defined by criteria or by process and finally whether it

## Events

6th Annual Bioethics Conference

Friday, March 12, 2004  
Susquehanna University

"Ethical Implications of the Medical  
Liability Crisis"

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7th Annual Palliative Medicine Conference

Thursday, March 18, 2004  
Bucknell University

"Issues Discussed and Issues Never  
Discussed"

## e-mail

The Bioethics Review and Advisory  
Committee's address is:

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The Bioethics Review and  
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should be cost blind or cost conscious. (*Cambridge Quarterly of Healthcare Ethics* 111: 127, 2002).

Futility cases are fraught with conflict because they are value laden and involve conflicting ethical and medical goals. Patients' families consider recommendations to withhold care to be an attack on family primacy in decision making (autonomy). In contrast, a physician's right to refuse treatment deemed to cause more harm than good (nonmaleficence) is held strongly as defense of his/her professional integrity.

A major evolution in the deliberation of medical futility was realized by a consortium of Houston hospitals (*JAMA* 276: 571, 1996). This group emphasized a process-based approach to resolve disputes in patient care emphasizing clear communication, negotiation and, if needed, impartial arbitration. Unlike others, this group included as their rationale "just allocation and good stewardship of medical resources." Other commentators have been careful to avoid rationing of care in a discussion of individually medically futile treatment.

Hamel and Panicola have emphasized that the major contributing factors to family requests for futile care are (a) inadequate communication between family and caregivers, (b) lack of clear understanding of the implications of that information for the treatment of their loved one, and (c) lack of clarity regarding treatment goals throughout the course of a patient's disease. (*Health Progress* July-August 2003).

So, how should one approach the above case? The physician should inform the family of the patient's disease and prognosis and reason why the intervention is medically futile. Alternative options, including palliative care, should be offered. The assistance of third parties, such as a nurse, social worker, chaplain or informed relative may facilitate communication. Consultation with another health care provider to support futility of medical treatment would be appropriate. If disagreement continues, a consult should be sought with the Bioethics Review and Advisory Committee. Exercise of the [Geisinger Medical Center futility policy](#) should be done as a last resort.

Respectfully submitted,  
*Joel Berberich*

The Bioethics Review and Advisory Committee gratefully acknowledges *The Degenstein Foundation*,

whose funding helps support the educational activities of our committee.



Feel free to forward *Bioethics Notes* to anyone interested. They can join by using the link below.

To join the list, send a blank email to List-Join: <mailto:join-bioethics@ghslistnt1.geisinger.edu>