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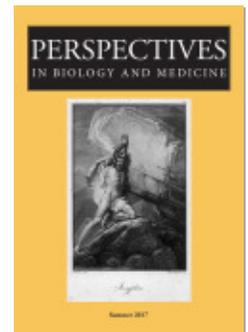
## Medical Futility and Involuntary Passive Euthanasia

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# MEDICAL FUTILITY AND INVOLUNTARY PASSIVE EUTHANASIA

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MICHAEL NAIR-COLLINS

**ABSTRACT** Conflicts between providers and patients or their families surrounding end-of-life care are both regrettable and extremely challenging, interpersonally and ethically, for all involved. These conflicts often implicate the concept of medical futility. The concept of futility is too often conflated with distinct concepts that are more ethically salient, including the fiduciary responsibility to assess surrogate decision-making, and distributive justice. By distinguishing these concepts from futility, it becomes clear that there are some situations in which forgoing life-sustaining treatment over objection is permissible, and perhaps even obligatory. But the justification lies in the constellation of rights and responsibilities surrounding surrogate decision-making, or in distributive justice, but not futility. Once futility is disambiguated from these other concepts, the practice of withholding or withdrawing life-sustaining treatment over the objection of a valid surrogate or a competent patient, based on the alleged futility of such treatment, is more clearly described as involuntary passive euthanasia.

CONFLICTS SURROUNDING THE PROVISION OF life-sustaining treatment create difficult ethical and interpersonal challenges for providers, patients, and families or other surrogates alike. These conflicts implicate a constellation of ethical concepts, including distributive justice, harms and wrongs to patients, fiduciary obligations to patients, standards for surrogate decision-making, and medical

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futility. Recently, several critical care societies published a policy statement on conflicts at the end of life, and advocated for a new concept, “potentially inappropriate treatment” (Bosslet et al. 2015). They argued that in some circumstances, after due process, physicians and hospitals should have the authority to forgo life-sustaining treatment over objection.

Schneiderman, Jecker, and Jonsen (2017)—early pioneers and continued advocates of a substantive concept of medical futility—have responded by arguing that this new term is unclear, generates confusion, and can be misleading. I concur. There has been a proliferation of euphemisms for “medical futility” in the literature, from “nonbeneficial treatment” to “not clinically appropriate” to “not medically indicated” and more (Wilkinson and Savulescu 2011). All of them, like “potentially inappropriate,” are mere euphemisms for medical futility.

Regardless of the term used to denote it, in this paper I argue that the *concept* of medical futility is too often conflated with other, more ethically salient concepts, creating confusion and muddled thinking about conflicts and policies at the end of life. Furthermore, I argue that once futility is disaggregated from these other important concepts, the practice of forgoing life-sustaining treatment over objection on grounds of medical futility amounts to involuntary passive euthanasia.

### DISAGGREGATING FUTILITY

Medical futility is often conflated with other concepts. This elision is highly problematic because some denials of life-sustaining treatment are permissible—and indeed, some may even be obligatory—whereas others are not permissible. Separating these important classes of cases requires clarity on the underlying concepts involved. To illustrate, I will present a series of cases allegedly involving medical futility. I argue that futility is not relevant in Cases 1 through 3, but that other ethical concepts are more salient; hence, unconsented removal or withholding of life-sustaining treatment would not be involuntary passive euthanasia in these cases. Only Case 4 truly draws on medical futility, therefore, forgoing life-sustaining treatment over objection in Case 4 would amount to involuntary passive euthanasia.

*Case 1.* An 85-year-old woman suffered anoxic encephalopathy after cardiac arrest and has been on mechanical ventilation in a busy hospital’s ICU for three months with no apparent neurological improvement and no rehabilitation facility willing to accept her transfer. Her son will not consent to terminal extubation and continues to hope for a miracle. Meanwhile, three other patients are on ventilators in the emergency department, because there are no available beds in the ICU. The hospital administrator wishes to remove ventilation for the patient in the ICU to allow space for another patient who has a better prognosis, and believes that doing so is justified because further treatment for the first patient is futile. (based on a case from Halevy and Brody 1996)

The concern in Case 1 is distributive justice, not futility. Maintaining the patient on mechanical ventilation is clearly successful in preventing hypoxemia and thus a fatal cardiac arrest. For the goal of keeping the patient alive, mechanical ventilation is efficacious, though it is unlikely that she will recover conscious awareness. The concern here is that there are other patients for whom that ICU bed would seem a more efficacious use of limited resources, and thus that maintaining the patient with such a poor prognosis in the ICU may be an unjust distribution of limited resources. Distinguishing futility and justice is critical, because the features of a case relevant to determining a just allocation of limited resources are very different from those involving futility.

First, in some instances it might be just to deny clearly beneficial treatment to someone. By contrast, futility never applies to cases of clearly beneficial treatment: if a treatment is beneficial it cannot be futile. Second, futility always applies to a single patient only, whereas distributive justice involves the distribution of resources among multiple patients. Similarly, futility is not relative to supply and demand. Even if resources were effectively unlimited, advocates of futility would argue that this is irrelevant, and futile treatments should not be offered regardless of resource availability. By contrast, justice is always relative to supply and demand. Fourth, justice is treating like cases alike. This demands that a general policy is needed to allow all similar cases to be treated similarly. On the other hand, futility is often decided on a case-by-case basis, especially with procedural approaches to futility. For all these reasons, futility and distributive justice are very different concepts and must be disambiguated.

*Case 2.* An elderly man is in the ICU for diabetic ketoacidosis and coma with very poor neurologic prognosis. Comorbid conditions include chronic obstructive pulmonary disease, congestive heart failure, renal failure with thrice weekly dialysis, and type 2 diabetes. Though he has spoken in the past with his physicians about not wanting aggressive life-sustaining treatment if he can no longer communicate, and that he wished to be made DNR, he never signed a formal DNR. His nephew is his surrogate, and he insists that his uncle would never have said he wanted to be DNR, and that the physicians manipulated him into saying what they wanted. The nephew further insists that “everything be done,” including dialysis and CPR, whereas the physicians assert that further treatment is futile and inhumane. It is later discovered that the nephew has been using his uncle’s Social Security checks and stands to lose those checks when his uncle dies.

Case 2 is an instance in which termination of life-sustaining treatment is obligatory, not merely permissible. The surrogate’s motives are highly questionable, and he appears to lack genuine concern for the patient’s well-being or prior wishes. Furthermore, the appropriate surrogate decision-making standard here is substituted judgment, and the surrogate is clearly violating that standard. The

physicians have a fiduciary responsibility to the patient to seek to override the surrogate and make the patient a DNR, and also to terminate life-sustaining treatment, on grounds of respect for the patient's precedent autonomy and fiduciary responsibility to the patient. These features of the case do not draw on efficacy or inefficacy at all: they draw on surrogate decision-making and the constellation of rights and responsibilities surrounding it.

*Case 3.* An infant born with multiple congenital abnormalities that rendered survival unprecedented required high-dose vasopressors to maintain blood pressure. After several days, gangrene developed in the extremities, and the parents sequentially demanded amputations of several limbs in an attempt to "do everything." The clinicians believe such treatment is futile. (from Halevy and Brody 1996)

This is another case where the concern is surrogate decision-making. Since the infant never could deliberate about such things, the appropriate standard is the best interests standard, or perhaps a harm threshold standard (Diekema 2004). On either of these, the balance of harms to benefits is terribly skewed, and the clinicians are appropriately concerned about causing grave harm to the dying infant without corresponding benefits. In this case as well, clinicians have a fiduciary responsibility to the patient to refuse to perform multiple sequential amputations, and if necessary, to take steps to override the surrogates. But again, the concern here is about excessive harm to the patient, and about decisions that clearly violate any reasonable standard for surrogate decision-making.

*Case 4.* A 56-year-old male is admitted to the hospital for an episode of difficulty breathing. He has cardiomyopathy, hypotension needing pressor support, liver cirrhosis and hepatitis B, chronic obstructive pulmonary disease, pneumonia, and renal insufficiency. While in the hospital he has a brainstem stroke and is intubated and ventilated and transferred to the ICU. He is now unresponsive and apneic, and the best evidence suggests he will not recover to wakeful awareness (but retains several brainstem reflexes). Prior to this hospitalization the patient, with decisional capacity, discussed with his wife and physician that he wants every chance at life, no matter how slim, and no matter how others perceive his quality of life. His wife is his surrogate and advocates that his wishes be followed and treatment continue. There are multiple open ICU beds and the patient's insurance is fully paying for all treatments; however, the physicians caring for him believe that further treatment is futile and seek to discontinue life-sustaining treatment.

The concern in Case 4 is not about problematic surrogate decision-making, nor about distributive justice. The concern here is truly about medical futility: Further treatment allegedly serves no meaningful goal because the patient is irreversibly unconscious and thus cannot appreciate the benefits of treatment as

a benefit; furthermore, it is very unlikely that a patient with such complicated medical problems can be discharged from an acute care hospital.

Schneiderman, Jecker, and Jonsen (1990) argued early on that effects must be distinguished from benefits. Medical treatment must benefit the *patient as a whole*, not merely cause an effect on the patient's anatomy or physiology. In this case, they would argue that medical treatment has many physiological effects, but it is no longer a benefit to the patient as a whole. Furthermore, Schneiderman and Jecker (2011) write: "The ends of medicine lie not with mere biological survival nor with the patient imprisoned within machines and tubes. At the very least, the ends of medicine require providing the patient with the capacity to participate in the human community" (19). Medicine no longer has the power to provide this patient with the capacity to participate in the human community, they would argue, so further treatment is futile, and life-sustaining treatment should be withdrawn. Indeed, life-sustaining treatment should be withdrawn even over objection, if the surrogate cannot be convinced to relent in her insistence on following her husband's wishes.

### **FUTILITY AND INVOLUNTARY PASSIVE EUTHANASIA**

Once disambiguated from other moral concerns, we can see that the justification for unilateral removal of life-sustaining treatment, and the predictable death that will occur, is the allegation that *life-sustaining treatment does not benefit the patient*. If this is the case, then it is in the patient's best interests to die or be allowed to die; or at least, it is in the patient's interests to die in the timing and manner that advocates of futility believe constitutes a good death—that is to say, sooner, and not while imprisoned in machines and tubes. Recounting a sample conversation between physician and surrogate, Schneiderman, Jecker, and Jonsen (2017) write: "Now the best kind of love you can help us give [your loved one] is a good death, a death that is worthy of [your loved one]." It must be emphasized that they are not merely advocating for a respectful conversation urging the surrogate to follow a particular path (no one challenges the propriety of this); they are advocating that physicians and hospitals may pursue that "good death" for such patients *even over the objection* of competent patients, or of valid surrogates following the appropriate surrogate decision-making standard.

*Euthanasia*, of course, means "a good death," a death that is in the interest of the one who dies. Furthermore, reciting some common distinctions here, active euthanasia involves taking an active step such as injecting a lethal drug, while passive euthanasia means to allow death to occur (when it could otherwise have been prevented or delayed), based on the justification that doing so is in the interests of the person who died. This is more commonly simply termed withholding or withdrawing life-sustaining treatment. And finally, voluntary euthanasia involves a competent request or consent by the person who dies; nonvoluntary

is when the patient lacks capacity and is unable to consent; and involuntary is against the competent patient's or valid surrogate's wishes.<sup>1</sup>

Examining Case 4 once again, it is clear that advocates of futility policies support causing or allowing death by removing life-sustaining treatment because it is in the patient's interest, or to give the patient a "good death," hence, euthanasia. It involves withholding or withdrawing treatment, not introducing a lethal substance into the patient's body, hence, passive euthanasia. Finally, and critically, the very purpose of futility policies is not merely to encourage palliative care or to encourage compassionate end-of-life care by clinicians (which, again, no one challenges). Instead, the purpose is to grant physicians and hospitals the authority to remove or refuse life-sustaining treatment, to pursue the patient's "good death," over objection. Therefore, the practice is most clearly described as "involuntary passive euthanasia."

One might respond that the goals of medicine do not include keeping people alive in such circumstances. I disagree with this assertion for several reasons and have made that case elsewhere (Nair-Collins 2015). For the purpose of this brief paper, however, nothing turns on what the goals of medicine are or ought to be. In fact, for the sake of the argument, let us assume that treatment in Case 4 provides no benefit to the patient as a whole. That simply makes my case: it endorses the idea that remaining alive through continued life-sustaining treatment is not a benefit; therefore, the motivation for refusing to provide life-sustaining treatment is that it is in the patient's interests to die. More specifically, the claim of futility advocates is that it is in this patient's interests, and similar patients' interests, to die one historically and culturally particular version of what some but not all people consider to be a "good death." Furthermore, this historically and culturally particular interpretation of a "good death" is alleged to be so strongly in the patient's interests that physicians are justified in forcing it on their patients who disagree, or whose surrogates disagree.

It is possible, of course, that involuntary passive euthanasia is permissible in some limited circumstances. But advocates of medical futility policies, like advocates of "potentially inappropriate treatment" policies, need to justify explicitly why involuntary passive euthanasia is permissible, if it is.

### RACISM IN MEDICINE

A final caution. Allowing hospitals and clinicians the authority to refuse life-sustaining treatment over the objection of patients or surrogates is likely to have

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<sup>1</sup>The most common use of *involuntary* refers to action or inaction that is against the competent patient's wishes. But since the valid surrogate is supposed to stand in for the patient—to speak on behalf of the patient—and since the valid surrogate has the authority to consent or refuse consent on behalf of the patient, it follows that *involuntary* is also appropriately used to refer to some action or inaction that is against the valid surrogate's wishes.

racially disparate outcomes, not only in actual removal of treatment but also in creating rather than assuaging interpersonal conflict. This is easily predictable because racism pervades all American institutions. In health care, it is manifested through health-care disparities, racially disparate treatment of pain, unconscious bias and its many effects on treatment decisions and on doctor-patient relationships, and the perpetuation of scientific racist mythologies among physicians and medical students, such as that black people have thicker skin or less sensitive nerve endings (Chapman, Kaatz, and Carnes 2013; Drwecki et al. 2011; Hoberman 2012; Hoffman et al. 2016; IOM 2003; Sabin and Greenwald 2012; Todd, Samaroo, and Hoffman 1993; Todd et al. 2000). Furthermore, African American or black families are more likely to prefer aggressive interventions at the end of life, and are rightfully less confident that their wishes would be respected by the health-care system, preferring instead to rely on their families to honor their wishes (Baker 2002; Perkins et al. 2002). It is therefore easily predictable that policies that authorize involuntary passive euthanasia through institutionally forced withdrawal or withholding of life-sustaining treatment will create a situation, as Wojtasiewicz (2006) has described it, of “yet another instance of disempowerment” at the end of life (9).

### CONCLUSION

Schneiderman, Jecker, and Jonsen (2017) are correct that the new euphemism “potentially inappropriate treatment” is unclear, misleading, and obscures more than it elucidates. But the concept of medical futility (regardless of the language used to denote it) is itself too often conflated with other, more ethically salient concepts, which creates the same muddled thinking as the term “potentially inappropriate treatment” does. Once we disambiguate futility from these other concepts, we see that there are some situations where it is permissible, and sometimes even obligatory, to forgo life-sustaining treatment over objection. These cases involve distributive justice and, perhaps more commonly, the fiduciary responsibility to assess surrogate decision-making. But in these kinds of cases, withdrawal of life-sustaining treatment is not justified by the alleged futility of treatment; it is justified by other, more defensible ethical concepts.

When those concepts are distinguished from futility, the remaining justification for removing life-sustaining treatment over objection is that death, or a particular manner or timing of death, is alleged to be in the patient’s interest; and furthermore, this is so strongly in the patient’s interest that it should be pursued even when patients or their valid surrogates disagree with this assessment. Therefore, forgoing life-sustaining treatment over objection and on the grounds of medical futility is involuntary passive euthanasia.

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