

The concept of medical futility is not similar to the concept of persistent therapy

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Authors' reply We are grateful for the letter of rev. dr Marcin Ferdynus, in which the author agrees that regulations in this matter are undoubtedly necessary, expresses several crucial doubts, and draws attention to important issues. It helps us clarify our position.

Firstly, the author suggests that we assumed that the concepts of medical futility and persistent therapy are similar and that we replaced the term “persistent therapy” with the term “medical futility” but retained the content of the definition of persistent therapy developed by the Polish Working Group (PWG) on End-of-Life Ethics in 2008.¹

We agree that the term “futile therapy” can be very imprecise and has many meanings, just like the term “persistent therapy”, and both have different origins and relate to different anthropological assumptions. For this reason, we wanted to make it more precise and used the definition developed by the PWG in 2008 (it should be emphasized that the English version of this definition used the term “overzealous therapy”, not “persistent therapy”)¹, by a wide community of medical doctors, lawyers, and philosophers. In this way, we wanted to apply the content of the definitions developed and well-known in Poland (used as the *definiens*), at the same time using the term “futile therapy” currently popular in English-language medical literature as the *definiendum*.

We believe that in the concept of both “persistent” and “futile” therapy, there is a space for the patient’s subjective opinions and preferences, if they can be obtained. However, our recommendations apply to the situation of a patient from whom an opinion cannot be obtained for objective reasons (“patient is incapable of making informed decisions regarding treatment”) and who did not indicate their surrogate decision making.

However, we emphasized several times that, whenever possible, the patient’s opinion should be reconstructed based on discussions with the

patient’s relatives. Due to these circumstances (beyond the doctor’s control) that make it impossible to obtain an opinion from the patient, the aim of our recommendations was to draw attention to objective (medical) indications that make a specific therapy pointless. The author also states that the term futile therapy in its basic and narrow sense better expresses the objective ineffectiveness of therapy (“The narrowest understanding of medical futility is an intervention that cannot accomplish its intended physiological goal”), and that the definition of the PWG is consistent with its content.

We agree that both terms (“persistent” and “futile” therapy) may apply not only to dying patients, but we have narrowed the analyzed population to this group of patients due to the following reasons: the frequency and high priority of decision-making in this group in medical practice, the lack of guidelines in this area, and the avoidance of ethical and legal controversies in the case of a too broad and imprecise use of this term in a broader population.

We are familiar with the definition of “overzealous” treatment (not “persistent therapy”), as stated in the Article 2278 of the Catechism of the Catholic Church (which refers to subjective preferences of a patient or their surrogate), but firstly, we wish to be guided by the medical rather than the ecclesiastical tradition, and secondly, we are not aware of any ethical or theological documents of the Catholic Church regarding treatment of patients who cannot express their opinion, are not legally incapacitated, and who did not indicate their surrogate decision making. Unfortunately, such situations are very common in hospital practice.

Secondly, the author points out that we have modified the content of the PWG’s definition of persistent therapy and instead of the term “patient’s good,” (or more precisely, “dignity”) we have used the term “patient’s best interests.”

Indeed, the Polish version of the definition was translated imprecisely, while the English original reads: “Overzealous therapy is the application of medical procedures with the goal of supporting vital functions in a terminally ill person that results in prolonged dying, and is associated with excessive suffering and/or with violation of the patient’s dignity. Overzealous therapy does not include basic nursing, control of pain and of other symptoms, or feeding and fluid administration, as long as these actions are beneficial to the dying person.”¹ The use of the term “best interest” generated discussion in our WG (and this category is only found in the English translation of the recommendation), but most of the coauthors chose to use the term “best interest” due to the popularity of this phrase in English. We are aware that British common law shapes the ethical content of the “best interest” notion (and it strongly differs from “dignity” in Polish law), but in the case of our guidelines, “best interest” should not be understood as a decision-making model based on the patient wishes (or other subjective convictions). We are aware that some authors contrast “dignity” and “best interest”, but we assume that both terms do not have to be contradictory in clinical framework, and “best interest” used in the guidelines should be understood in the sense of searching for the best solutions for the patient understood objectively (medically and within the framework of clinical consilium), taking into account the knowledge about patient’s values and preferences obtained from their loved ones. And it does not exclude reference to dignity, because this category is obviously crucial in the Polish ethical tradition and in the Polish legal order (Article 30 of the Constitution of the Republic of Poland). Moreover, in a scoping review on the understanding of the term “best interest” in bioethics, it was noted that in some approaches the category of “dignity” plays an important role in conceptualization of the “best interest”.² Examples of legal acts that simultaneously use the concept of “dignity” (eg, Preamble, Articles 3(1), 9(1), 18, 20, or 21 of the United Nations Convention on the Rights of the Child) and “best interests” (eg, Preamble, Articles 23(1), 28(2), 39, or 40(1) of the United Nations Convention on the Rights of the Child)³ can also be given. We emphasize that in the interpretation of our guidelines the term “best interest” should be understood in meaning of “patient’s good,” and taking into account the patient’s dignity in accordance with the centuries-old tradition of medical ethics, the Polish Code of Medical Ethics, and Polish law.

The author recalled the discussion around the case of a Pole in a vegetative state who was discontinued from feeding in the United Kingdom based on the local legal category of “best interest” (RS case). We would like to emphasize that some of us were critical of the course of action adopted in the United Kingdom in the RS case, and expressed this in a position statement emphasizing the dignity dimension of his existence.⁴ We

therefore recognize the importance of the concept of dignity in determining the inherent and inviolable value of a human being, but we are aware of its limitation largely to the philosophical tradition of human rights and Christianity.

Finally, the author has suggested that our position is characterized by a paternalistic approach and the final decision regarding withholding or withdrawing therapy lies with the physician (medical team). We do not agree with this objection. It should be emphasized that the statement in our position paper that “the aim of the meeting (with family members) is not to obtain permission from the family to implement or withdraw from medical interventions, as from a legal perspective their opinion is irrelevant” indicates regulations of the Polish law that cannot be changed by clinical guidelines. However, we repeatedly emphasized that the doctor should not make the decision not to start or to discontinue therapy on their own, and stressed the role of meetings with the family and loved ones, consultations with chaplains, ethicists and other doctors, and the need to take into account the patient’s previous wishes and preferences (if known). The aim of such a procedure is to discover together (in a dialogue between doctors, family members, and other clinical team members) what course of action is the best for the patient, serves their good, and respects their dignity. Ultimately, doctors are still burdened with moral and legal responsibility for making clinical decisions, especially in situations where the patient is unable to express their opinion. The role of medical experts in such a situation is also emphasized by the Vatican Declaration *Iura et Bona*: “for such a decision (withholding or withdrawing therapy) to be made, 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”(p. IV).⁵

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CONFLICT OF INTEREST None declared.

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