Futility Clarified

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Futility has had a rough time in recent medical ethics literature. From about 1987 to 1996, various writers and groups tried to define futility within the context of medical treatment, but without success.[1] Baruch Brody and Amir Halevy give an excellent summary of the morass in their 1995 article "Is Futility a Futile Concept?"[2] where they argue that none of the then-proposed definitions succeed. While a smattering of other attempted definitions have appeared since then,[3] for the most part writers about futility have found it more profitable to stop trying to define futility and instead move in a different direction, that of figuring out how to resolve disputes where patient families want more treatment which clinicians think is futile.[4] This is, for example, the approach taken by the Texas Advance Directives Act (1999), which was the first futility legislation in North America and is often seen as an appropriate template.[5] The idea embodied in this influential legislation is that our energies should be focused on creating a process which we can use to resolve difficult cases, and which everyone finds legitimate, rather than in trying to find a definition which everyone finds legitimate.[6]

Indeed, if any consensus on the question of definition has been reached at all, it is that the concept of futility is so vague and open-ended that no purported definition can be adequate. For example, the 1996 *JAMA* report on Houston's futility policy (which was, of course, an ancestor of the 1999 Texas Advance Directives Act) urges that we abandon the effort to define it and instead embrace the attitude that we know it when we see it:

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The basic problem is that the clinical reality of the uniqueness of patients and diseases results in judgments of futility that are not easily formulated into a general substantive definition. We concluded that we need to treat futility as the courts treat pornography, acknowledging that while it cannot be defined, we certainly know it when we see it.[7]

I take a contrary view in this paper. I argue that we have given up too soon, and that the definition of "futility" is in fact straightforward: futility is uselessness. I will also show that the position I sketch is sensitive to the daunting complexity and seeming hopelessness of the situation that has caused other writers to give up looking for definitions and move instead to questions about how to mediate disagreements. It will turn out that though it is a simple and straightforward task to define futility, there is another closely related task lurking about which is dauntingly complex and seemingly hopeless. In other words, there are two problems surrounding futility: one easy, one hard. I will argue that the definitional problem is easy, but the hard problem, which cannot be resolved in a short bit of text, is not properly a problem of definition.

Previous Attempts

Let us begin with a brief survey of the terrain of previous attempts at defining futility. Here I borrow heavily from Baruch Brody and Amir Halevy's 1995 article "Is Futility a Futile Concept?" which divides potential proposals into four different types. First *physiologic*, where an intervention is futile if it does not lead to its intended physiologic effect. An example is CPR, which is physiologically futile when it cannot lead to spontaneous heartbeat. Second is *imminent demise*, where the treatment will not affect the fact that the patient

will die within a few weeks or months (but not years). An example of this is CPR restoring spontaneous heartbeat in a patient who will die very soon anyway due to advanced cirrhosis, which CPR cannot affect. Third is *lethal condition*, which is like imminent demise except that it drops the requirement that the treatment has no effect on the patient's underlying fatal disease state. Finally *qualitative* futility appeals to quality of life. For example, CPR is qualitatively futile for a patient in persistent vegetative state, because the quality of life in such a state is so poor.

After distinguishing these potential types of futility, Brody and Halevy survey various proposed definitions, showing how they fit in one or another of these categories or, just as often, showing how they are ambiguous between two of them. I will not repeat their survey here, but they take on such candidates as the Ameri-

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can Medical Association's 1991 Council on Ethical and Judicial Affairs, the third edition of the *American College of Physicians' Ethics Manual* (1992), the 1992 National Conference on Cardiopulmonary Resuscitation and Emergency Cardiac Care, the American Thoracic Society (1991), the Society of Critical Care Medicine (1990), the 1983 President's Commission, the 1985 Baby Doe statute, and the 1992 New York Task Force on futility of resuscitation. In each case they discuss how the various proposals fit into one or more of the above four categories.

Then they argue that no proposal is adequate, on grounds that any definition must be precise, prospectively applicable, socially acceptable, applicable in a reasonable number of cases, and not assume patient or surrogate agreement. I will not review their argument here, because I agree with their conclusion — none of the definitions so far offered have been adequate. In a later section, I will offer my own definition, one of an entirely different sort than the ones so far dismissed. But first I want to discuss an implicit assumption that often accompanies discussion of futility, namely that futility must revolve around life-sustaining measures.

Once we jettison this erroneous assumption, it will be clearer why my own definition is appropriate.

Futility without the End of Life

Writers on futility often focus their attention only on cases of life-sustaining treatment or cases of treatment at the end of life. Thus, for example, in an early attempt, Lawrence J. Schneiderman et al. define a qualitatively futile treatment as one which "merely preserves permanent unconsciousness or that fails to end a patient's total dependence on intensive medical care."[8] Even three of Halvey's and Brody's four categories deal exclusively with such cases — imminent demise, lethal condition, and quality of life. Indeed, many of the proposed definitions they examine discuss futility only in the context of resuscitation, where the outcome of mortality is understandably the most prominent.

For example, the National Conference on Cardiopulmonary Resuscitation and Emergency Cardiac Care states that one circumstance in which resuscitation is futile is when there are no survivors to hospital discharge,[9] and the American Thoracic Society tries to be slightly more nuanced in qualifying that constraint so that what counts is meaningful survival, where this takes into account both the duration and the quality of the patient's life.[10]

Unfortunately, that is still not nuanced enough. Futility applies even in cases where survival and end-of-life are not issues. Allan Brett and Laurence McCullough's 1986 "When Patients Request Specific Interventions" broaches the topic of futility, even though it never uses that word.[11] That paper rightly discusses general cases of futile treatment, such as giving antibiotics for viral upper respiratory infections, and did not limit itself to end-of-life care. If futility is not essentially connected with end-of-life issues, then why does the more recent literature that comes after Brett and McCullough focus so myopically on the end of life? I conjecture that it is because end-of-life care is very important, so that, first, writers on futility naturally gravitate towards such cases, and, second, the need for clarity is most urgent in such contexts. If we make the wrong choice in the vicinity of the end of life, someone dies (or mistakenly lives), whereas if we make a mistake about whether to give antibiotics for a viral infection, we merely squander some resources and contribute to resistance (which indirectly squanders resources as well).

Indeed, I suspect that this myopic focus on the end-of-life is also partly responsible for the conceptual confusion that has resulted in the literature on futility, in the attempts to define that concept. Once we recognize that giving antibiotics for viral infections is futile

in the same sense that performing CPR is when it has no hope of restoring spontaneous heartbeat, then it may be more clear just what is at stake in defining futility: not much.

Defining Futility

It is easy to define futility, once we jettison the mistaken and distracting idea that it applies only at the end of life. Futility is *uselessness*; to say that a treatment is futile is to say that it is useless. Equivalently, it is to say that the treatment is pointless, that there is no point in implementing it. Equivalently, it is to say that it is ineffective. The concept of futility is univocal and easy to grasp; there is nothing complex or murky about it. To narrow our discussion to just one of the synonyms I proposed, we can say that a treatment is futile if and only if it is useless. We obviously already understand the concept of uselessness; futility is no more difficult to understand.

The best way to argue for the synonymy of "futile" and "useless" is indirectly. That is, I will not offer a series of independently plausible and non-question-begging premises which jointly entail that "futile" is synonymous with "useless." However, this is not worrisome for my position, for the same reason that it is not worrisome for the synonymy of "doctor" with "physician" that it is nearly impossible to produce an argument for that latter synonymy via a series of independently plausible and non-question-begging premises which jointly entail it.[12] This is not to say that one can never produce deductive, non-circular arguments for analytic conclusions. We can produce such arguments in mathematics, for example, and this is compatible with the (contentious) thesis that mathematics is analytic. However, the synonymies between "futile" and "useless" and between "doctor" and "physician" are in some sense, which I here leave unexplored, much more basic and fundamental than alleged mathematical synonyms, if there are such things.

Still, I can offer some indirect arguments. One straightforward, yet indirect, argument for the synonymy of "futile" with "useless" appeals to the intended function futility assessments play in clinical care. The point of making a futility determination in clinical care is to allow medical professionals to withdraw or withhold care against a patient's or family's wishes, when the care team thinks such care is futile. But, of course, the clinical care team is "also" morally permitted to withdraw or withhold care against a patient's or family's wishes when they think such care is *useless*. I put the word "also" in scare-quotes in the previous sentence to flag that this is not really a second consideration that licenses withdrawing or withholding care; it is the same consideration stated using a dif-

ferent word. When we want to describe a situation where clinicians might be permitted to withdraw or withhold care because such care would be pointless, we can use "futile" or "useless" (or "pointless") interchangeably to make that point. Therefore, at least in the context of clinical care, those two words are effectively synonyms.

Another indirect way to argue for the synonymy of "futile" and "useless" is by showing how alleged scenarios in which a treatment is futile yet at the same time useful (or useless yet not futile) are incoherent. How might such a scenario arise? One suggestion is that, for example, CPR for a person in a persistent vegetative state is (qualitatively) futile, and yet not completely useless because, after all, it might restore the patient's cardiac function, which is of some limited use. However, this sort of strategy for rejecting the synonymy between futility and uselessness betrays a confusion. Both futility claims and usefulness claims are (often implicitly) relative — they both are claims about futility or uselessness in relation to a particular goal or endpoint.[13] For example, to say that CPR for a person in a persistent vegetative state is futile is shorthand for saying that it is futile for achieving the goal of restoring quality of life. To say, in the same breath, that it is useful is shorthand for saying that it is useful for achieving the *different* goal of restoring cardiac function. But once we fix the goal in question, it cannot be the case that CPR is both futile yet useful (or useless yet not futile) for achieving the very same goal.

Another way in which one might attempt to block the synonymy between "futile" and "useless" is by suggesting that the point of a medical team making a formal futility assessment is not merely to say that a treatment is useless. Rather, it is to communicate that the clinical team is so certain of uselessness that it is permissible for the team to withdraw or withhold care, in spite of the patient's or family's wishes. Therefore, the worry continues; futility cannot merely be uselessness. Rather, it must include an element of degree of confidence: perhaps futility is certitude of uselessness.

This suggestion is incorrect, because it fails to distinguish truth-conditions from assertability-conditions. As an analogy, compare the straightforward synonymy of "doctor" with "physician." Even though these words are synonymous, in some contexts it might be more appropriate to use the word "physician," and in other contexts "doctor." For example, "physician" might be appropriate in more formal contexts and "doctor" more appropriate in more casual ones.[14] Likewise, it might be for pragmatic reasons that clinicians should not use the word "futile" around patients and families until they are sure that the treatment is useless, but this claim can also be stated as saying that clinicians

should not use the word "futile" around patients and families until they are sure that the treatment is futile. After all, it is not a contradiction to say "I think the treatment is futile, though I am not sure that it is." And compare an analogous move in the definition of death: epistemic certitude on the part of the pronouncing clinician plays no role in defining when someone is really dead, even though there may be very good pragmatic reasons for clinicians not to use the word "dead" unless they are absolutely sure.

A final objection to my synonymy claim contends that offering synonyms such as "useless" is not illuminating, because it merely shifts the question of definition off the original term and onto the new synonymous one. But that is not true, because sometimes we have a better understanding of the synonym than we did of the original term. For example, telling a small child that justice is fairness may be illuminating, if she understands fairness but "justice" is new to her vocabulary. Something like this is apt to occur for futility, if only because the word "futile" is in less common parlance than "useless," "pointless," and "ineffective." Indeed, one potential explanation for the burgeoning literature on futility is that "futility" is less in the colloquial mainstream than its proposed synonyms such as "useful"; it is a bit of fancy technical jargon which invites attempts at definition. In contrast, think how bizarre it would be to see a new medical literature spawn up attempting to define the word "useless."

Applying Futility

Now, the definition of futility is not complex or murky, but what might be complex and potentially murky is the reason that a particular treatment is futile.[15] Here are four such potential reasons (there may be others): *physiologic* ineffectiveness, *imminent demise*, *lethal condition*, and *quality of life*. Brody and Halevy, and indeed all the previous literature on futility, assumed that these were different candidate definitions for that concept. As another example, recall Lawrence J. Schneiderman et al.'s definition of a qualitatively futile treatment as one which "merely preserves permanent unconsciousness or that fails to end a patient's total dependence on intensive medical care."[16] I suggest, to the contrary, that these are not different ways of resolving an ambiguity in "futility"; they are merely different reasons a treatment might be futile. For example, a treatment might be futile because it merely preserves permanent unconsciousness, but this is not yet to say that futility means (in this case but perhaps not in others) merely preserving permanent unconsciousness.

As an analogy, consider the fact that some members of the San Francisco Giants came to the team via free agency, others were promoted from their minor league system, and yet others were acquired in trades. One might become a San Francisco Giant in many ways. Likewise, abstracting from ways in which one might join the team, there might be many different reasons various players became members of the team. One player may have been acquired to shore up left-handed middle relief. Another might have been acquired to bring speed to the top of the lineup. And so on. Does any of this mean that "member of the San Francisco Giants" is ambiguous? Of course not. We do not say that in one case being a member of the Giants means being a left-handed reliever, and in another case it means bringing speed to the top of the lineup. No; there is one univocal concept of "San Francisco Giant" which is easy to grasp, even if the ways in which one might qualify as a Giant are multifarious. The same conclusions hold for the concept of futility. We have a univocal concept of futility, in spite of the fact that there might be many reasons to make a futility judgment.

In other words, it might be difficult to ascertain whether a treatment is futile, but in two ways. One way is if we are not sure what it means to be futile. This way is operative when, for example, someone cannot ascertain whether ontogeny recapitulates phylogeny, because she does not know what those words mean. The other way is relevant if we are clear on the meaning of the words but we are not sure what reason we have to say that it applies to the thing in question.[17] For example, we might have a very clear idea of what "affluent" means, and still have a hard time figuring out whether someone is affluent (and not just because of vagueness), because we have a hard time assessing that person's total net worth, given her multifarious inter-connected assets and debts. The debate over futility is difficult in this latter way: we understand clearly what it means to be futile, but we are asking *why* this treatment is futile, or what reason we have to say that a treatment is futile. I will call this difference that between *defining* and *applying*: to define futility is to give a conceptual analysis; to apply futility in a particular case is to give reasons for thinking that some particular treatment is futile.

Why Defining Fails to Address the Practical Problem

Does the distinction I just made, between defining and applying, make a practical difference? Who cares whether we call our trouble one of definition or one of application? The quandary in particular cases remains: what criteria are we going to use in determining whether treatment is futile, which clinicians can use to justify withdrawing or withholding treatment against a patient's or family's wishes? That is

the important question which has led some writers to throw up their hands and instead focus on how best to mediate disputes.

Well, in a sense this objection is correct, that the important practical question is as yet unaddressed. But in its haste to resolve the practical question this objection is insensitive to more theoretical issues, which are important too. There are some troubling concepts whose conceptual analyses have eluded the best professional thinkers who work in those areas. Knowledge might be one such; welfare might be another. But futility is not, and it would be a serious mistake to lump it in with those other, difficult-to-define concepts.

practice within the space of a paragraph? If so, then she will have given us a nice and tidy generic explanation for the non-futility of treatments in general — i.e., for their efficacy and indication — that we would be able to use in clinical practice to adjudicate in hard cases whether a certain treatment is useful. Thus, if it were possible to give a short definition of futility that is also clinically useful, we would have all the information that aspiring clinicians traditionally acquire only after years of training and education. In other words, this converse problem is what aspiring clinicians go through years of training to learn how to solve: the problem of being able to tell when certain treatments are indicated and when not.

> The central theme of my argument is conceptual, not practical, and yet it has practical import. We all know what futility means, and yet it can often be a difficult problem to determine when any particular treatment is futile, perhaps in part because we are not clear on what the goal of the treatment or its anticipated endpoint is.

Further, even if we are willing to accept the taxonomical mistake as a small price to pay for being able to speak easily about the more urgent practical problem, the distinction between definition and application can still give us insight about how best to address the more urgent and difficult practical problem. That is because the proposed synonyms — "useless," "ineffective," and "pointless" — are more clearly than "futile" syntactically negative expressions, that is, expressions which are formed by negating more basic positive expressions — "useful," "effective," and "having a point." This suggests a relevant contrast to our difficult question of being able to tell when a treatment is futile, namely what it is for a treatment to be useful, effective, and to have a point.

Writers have faced insurmountable difficulties when attempting to define futility in a nice and tidy way that is also capable of adjudicating in every case whether a treatment is indeed futile. That is because that problem boils down to trying to show, in general, when any treatment is ineffective and therefore contraindicated. But now consider the converse problem of defining non-futility and applying non-futility to particular cases. That converse problem boils down to trying to show, in general, when any treatment is efficacious and therefore indicated.

Do we expect that any writer will be able to resolve this converse problem for the purposes of all clinical

But, of course, that is absurd; this converse problem, of determining the appropriate criteria to judge whether a certain treatment is indicated, is not soluble within a paragraph, or even within the confines of a paper or book. More precisely, it is not possible to give in such a short amount of space some criteria from which we can determine, using that bit of text and nothing else, whether any particular treatment is useful and effective in any particular case. At most, such a short bit of text would give us only generalities which may be good at articulating starting principles but will not suffice to make any practical recommendations.[18] Thus, while clinicians might have appealed to medical ethicists for a precise notion of futility which they could then wield as an ethical shield whenever they decided that some treatment was contraindicated, no such facile shield can be forthcoming.

The problem is not that we cannot give simple clinical algorithms and guidelines in particular cases — such as what to do when a patient comes into the ER complaining of chest pain — that can be written down on a note-card and quickly absorbed. Indeed, evidence-based medicine is based on the idea that such algorithms can often be generated and are useful clinically. I have no dispute with evidence-based medicine. Rather, my point is that we cannot expect to be able to fit all of medicine on a note-card. In other words, we cannot write down a brief guideline that will deter-

mine, for every illness a clinician might encounter, exactly what to do about it.[19] And yet that is what we demand, if we demand that futility be defined in such a way that clinicians can tell, just by absorbing that definition, whether any arbitrary treatment is futile.

Another caveat is in order. The correct application of futility relies on clinical judgment, which is complex in its own right, though not so complex as to be mysterious or unanalyzable, as the courts think pornography is. Clinical judgment as a whole, though perhaps not in certain discrete situations, is too complex to reduce to simple algorithms or deductive reasoning from a small number of premises to a conclusion about right action. Rather, it involves both scientific reasoning and normative reasoning, as well as much practical experience. For example, a clinician is trained to know scientific facts regarding the effectiveness of various antibiotics against various infections, and she is also trained to make judgment calls about when it is appropriate to treat infections and when it is more appropriate to refrain. And she will also need to be trained in various diagnostic and therapeutic skills, which involve practical experience — for example, clinical exam skills, such as how to palpate for and recognize hepatomegaly — as well as reasoning. The point is not that clinical judgment is in principle opaque and closed to analysis, but rather merely that it is as a whole too complex for its lessons to be stated briefly, such that an aspiring clinician need merely absorb that amount of text and nothing else, to qualify as competent.

Given this, it is no wonder that the literature on futility is increasingly pessimistic about the likelihood of finding a practically useful definition of futility. To resolve this hard practical problem, the problem of how to apply futility correctly to a wide range of particular cases, we must undertake years of medical training, just as aspiring clinicians do. This pessimistic conclusion is less surprising on the view that defining futility is easy but applying it is hard than it is on the assumption that its truth-conditions and application-conditions (and assertability-conditions) can be stated briefly. Therefore, the pessimistic conclusion that we must undertake years of training to learn when treatments are futile lends credence to the former view, that defining futility is easy but applying it is hard.

Now, I grant that a treatment might be contraindicated for reasons other than ineffectiveness — the treatment might be effective but less so than an alternative; it might be too costly; it might be too time consuming; it might incur too great a risk of harm; or some combination of the above; and so on. And clinicians go through years of training to learn these things too, along with other things besides. But surely it is not that these other things are the ones that keep them in school for so many years, whereas learning about contraindication due to ineffectiveness requires merely absorbing a the contents of a note card.

Further, recall that futility assessments are relative to the goal of the treatment in question. Now, it is often a very hard problem to determine what the goals of treatment ought to be, but the definition of futility is, appropriately, silent on that question.[20] When we ask whether or why some particular treatment is useful, we are not asking for the definition of usefulness; rather, we know what it means to be useful, and we are asking what the intended use of the treatment is or ought to be, in order to assess whether this or that treatment counts as useful, by the very definition of usefulness that we already recognize. And, clearly, this last assessment is not one that can be articulated briefly; it is one that clinicians spend their professional lives trying to learn.

The Clinical Reassessment of Futility

The central theme of my argument is conceptual, not practical, and yet it has practical import. We all know what futility means, and yet it can often be a difficult problem to determine when any particular treatment is futile, perhaps in part because we are not clear on what the goal of the treatment or its anticipated endpoint is. The problem is hard because often even the experts are unsure of their answers, but that suggests a natural solution in cases of disagreement between a clinician and her patient (or surrogate): call in more experts. Presumably a group expert opinion on a hard question is more likely to be correct than any individual expert opinion on the same subject.

Calling in more experts is essentially the solution proffered by Amir Halevy and Baruch Brody in their 1996 article, "A Multi-institution Collaborative Policy on Medical Futility." To simplify their procedure, they suggest asking for a second medical opinion and then submitting the case to an interdisciplinary committee for review.[21] Interestingly, they suggest that the review body be interdisciplinary. In the remainder of this paper, I want to take for granted that the right strategy in cases of dispute is to call in more experts, and I want to explore one question that arises on that assumption: given that the proper practical step to take in cases of disagreement is to ask for more expert opinion, in what sense should that second opinion be interdisciplinary? Would it suffice if the second opinion was that of another medical expert, or does it have to include ethical experts as well? It may need to include other voices besides, but I further limit my exploration just to medical and ethical experts.

The right answer is that it depends, and my previous analysis will be helpful in illuminating the ways in

which it depends. Let us distinguish between descriptive claims and normative ones. Descriptive claims tell us the way the world actually is, whereas normative ones tell us how it ought to be. Perhaps this distinction represents two extreme ends of a spectrum, and most claims are somewhere in-between; perhaps not. In any case, the distinction is clear, and those who think that no claim occupies either extreme of the spectrum are invited to replace my simpler predicate "...is descriptive" with "...is *mainly* descriptive," and similarly for the simpler "...is normative." Questions about diagnosis, for instance, are descriptive — the patient either has diabetes or not, and whether she does reflects the way the world is. Likewise, questions about whether a certain treatment can cure or control a disease are descriptive — insulin either can or cannot control her diabetes, and whether that is so reflects the way the world is.

In contrast, statements about the goals of treatment are normative — to say that it is appropriate to extend life only in some cases but not in all cases is a normative claim, not necessarily a description of the way the world is, but rather an insistence on how various people ought to go about behaving in it. Likewise, to say that the goal of giving antibiotics is to eradicate an infection is to make a normative statement about how we ought to allocate resources. Combining that with the descriptive claim that antibiotics will not affect viral infections, along with some other innocuous premises besides, we can derive the conclusion that giving antibiotics to a patient with a viral infection is futile.

Now, in some cases the goals of the allegedly futile treatment are clear and not in question. For example, the goal may be eliminating the viral infection, and the treatment may be antibiotics. What is in question is only whether the treatment has any effect on that goal. In that case, what is required for resolution is not normative expertise in figuring out what the proper goal of treatment should be but rather descriptive expertise in figuring out whether the treatment can actually bring about that goal. If there is disagreement in such a case, more medical expertise seems appropriate, and normative expertise seems unnecessary. Therefore, it seems sufficient in this sort of case that the second opinion include more clinicians, not ethicists.

A couple of caveats are in order. First, I assume that ethicists have expertise on normative claims. This is contentious on at least two fronts — (a) whether normative expertise is possible, and (b) whether professional ethicists have it to a higher degree than other people. These are large issues, and I merely point them out here and continue to assume as I stated above. Second, I also assume, perhaps controversially,

that a doctor is permitted to rely on her own descriptive expertise, and those of her professional colleagues in cases of doubt, as opposed to the patient's, in judging whether to treat. (This does not imply, of course, that the clinician can use her own value judgments, for example as to what constitutes a meaningful life, over her patient's.) So normative expertise might be required in this derivative way even in cases where the contention is purely descriptive: normative expertise might be required to assure the clinician that she is allowed to withhold treatment on the basis of her own descriptive (medical) expertise. But that general normative claim applies in every such case; what is not needed in such cases is individualized normative expertise that helps adjudicate the controversial descriptive claims in doubt.

Sometimes, as discussed above, only descriptive claims are at issue. In other cases, however, the very goals of treatment may come into question. In such cases, the reason we are unclear about whether a treatment is futile is that we are not clear on what the point of treatment really ought to be. We might be clear on descriptive claims about the extent to which the treatment affects various outcomes, but we are unclear on which outcome should be our goal. For example, we might wonder what the goal of treating pneumonia is for a patient in a persistent vegetative state. Antibiotics will reliably treat the infection, but they will not reverse the patient's cortical damage. In such a case, we need more normative expertise, not more descriptive expertise.

Still, we cannot yet conclude that we therefore need ethicists and not clinicians to give our second opinion when there is normative disagreement. That is because clinicians, besides being trained about descriptive medical facts, are also trained to make normative judgments about when to treat and for what reasons — every doctor is trained to have an opinion on whether to give antibiotics for viral infections, for example. But the point is that *only* in this sort of case, where the goal of treatment is up for grabs, is it even potentially necessary to ask for an ethicist's opinion regarding futility. Here, and here alone, is there even a potential need for an interdisciplinary body — one that includes ethicists — to assess whether treatment ought to be withdrawn because futile.

Of course, it might turn out that sorting out all these intricate issues involves expertise of yet a third sort — conceptual clarity and critical thinking. However, conceptual clarity and critical thinking are plausibly the sort of expertise that everyone involved ought to possess anyway, ethicists due to the intimate connection of their field to philosophy generally and clini-

cians because their own profession is so intellectually demanding.

Where does all this leave us? The interim lesson to glean here, without delving into even more specifics, is that these issues matter. That is, it matters whether disagreement is descriptive or normative. Sometimes what seems like an ethical quandary really reduces to a medical quandary, in which case more medical expertise is necessary, but ethical expertise is not. For example, whether we respect a patient's wish to leave the hospital might reduce to the diagnostic problem of whether she is psychotic. The diagnostic problem may be difficult, but it is predominately medical (descriptive), and our ethical obligation, once the diagnosis has been determined, is clear. In such a case, the proper thing to do is to call in more and better psychiatrists, not necessarily ethicists. Some cases of futility might turn out just like that, and part our responsibility in investigating a case of alleged futility is to determine just what sort of expertise is necessary to provide an appropriate second opinion.

Conclusion

In this paper I have argued that we ought to distinguish defining futility from deciding whether to apply it in particular cases. Defining "futility" is easy — it is synonymous with "pointless," "useless," and "ineffective." Applying futility to particular cases, on the other hand, is hard. Not only is it hard, but it is also the task that clinicians train their entire lives to be able to accomplish. Thus, we should expect that there is no easy answer, one both short enough to fit on a notecard and also practical enough to serve as a guide to determine when any particular treatment is futile. I have not attempted to give a complete answer about what to do in hard cases. Indeed, if I am right, then that task is impossible: it is impossible to articulate in a short amount of text all the considerations that are relevant in determining, in any conceivable scenario, when medical professionals should treat, and when they should refrain. Rather, I addressed the logically prior, if more modest, issue of conceptual clarity, which is important too.

It is also worth mentioning, in conclusion, the source of the conceptually confused attempt to define futility: using jargon when simpler, more common, and better-understood synonyms — such as "useless" — would have sufficed. There is, of course, the important ethical issue of determining when medical professionals may stop useless treatment in spite of a patient's or family's wishes to the contrary, but it is a mistake to adopt a bit of jargon — "futility" — and then claim that this important issue can accurately be re-described as how to define it.

References
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2. B. Brody and A. Halevy, "Is Futility a Futile Concept?" *Journal of Medicine and Philosophy* 20, no. 2 (1995): 123-144.
3. Most notably and recently, R. K. Mohindra, "Medical Futility: A Conceptual Model," *Journal of Medical Ethics* 33, no. 2 (2007): 71-75.
4. See, for example, H. Brody, "Medical Futility: A Useful Concept?" *Medical Futility and the Evaluation of Life-Sustaining Interventions*, M. B. Zucker and H. D. Zucker, eds. (Cambridge, U.K.: Cambridge University Press, 1997): at 1-14. Brody there argues that the right way to resolve disputes is to appeal to the metaphor of conversations. Again, a nice overview of this history is provided in Helft, Siegler, and Lantos, *supra* note 1.
5. *Available at* <http://tlo2.tlc.state.tx.us/statutes/docs/HS/content/htm/hs.002.00.000166.00.htm> (last visited July 2, 2009).
6. See R. D. Troug, "Tackling Medical Futility in Texas," *New England Journal of Medicine* 357, no. 1 (2007): 1-3.
7. A. Halevy and B. Brody, "A Multi-Institutional Collaborative Policy on Medical Futility," *JAMA* 276, no. 7 (1996): 571-574, at 571.
8. L. J. Schneiderman, N. S. Jecker, and A. R. Jonsen, "Medical Futility: Its Meaning and Ethical Implications," *Annals of Internal Medicine* 112, no. 12 (1990): 949-954, at 952.
9. American Heart Association, "Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care," *JAMA* 268, no. 16 (1992): 2171-2298, at 2238.
10. American Thoracic Society, "Withholding and Withdrawing Life-Sustaining Therapy," *American Review of Respiratory Disease* 144, no. 2, part 1 (1991): 726-731, at 728.
11. A. S. Brett and L. B. McCullough, "When Patients Request Specific Interventions: Defining the Limits of the Physician's Obligations," *New England Journal of Medicine* 315, no. 21 (1986): 1347-1351.
12. I encourage the reader to try this to see both that it is nearly impossible and that it is unnecessary. (I say "nearly" because for some contentious synonymous pairs, there might be some third term which is uncontroversially synonymous with both the other two. One could then use the transitivity of synonymy to construct a direct argument for the contentious synonymy in question.)
13. The distinction between use and goal is obvious and becoming more explicit in recent discussion of futility. See, for example, Mohindra, *supra* note 3, and H. Brody, "Bringing Clarity to the Futility Debate: Don't Use the Wrong Cases," *Cambridge Quarterly Healthcare Ethics* 7, no. 3 (1998): 269-273.
14. Leaving open whether meaning is reference or some Fregean sense, Frege is still careful to distinguish coloring (or tone) from both of these. Two synonyms might share sense and reference yet still differ in their coloring, which Frege suggests will be a relevant feature when poetic eloquence is at stake, but not truth-conditions. See G. Frege, "Über Sinn und Bedeutung," *Zeitschrift für Philosophie und Philosophische Kritik* 100, (1892): 25-50.
15. Another issue that might be complex, as discussed earlier, is when it is appropriate to assert a futility claim or, perhaps equivalently, when we can be sure enough of futility to stop treatment.
16. See Schneiderman et al., *supra* note 8, at 952.
17. Again following from earlier discussion, there is a third possibility. We may be clear on what the word means and clear

on the reason(s) we have for applying it, and yet be unclear on whether it is appropriate to assert claims using that word, for example because we think a certain degree of confidence is required before making authoritative assertions.

18. See K. D. Clouser and B. Gert, "A Critique of Principlism," *Journal of Medicine and Philosophy* 15, no. 2 (1990): 219-236.

19. The difference here is one of logical scope. The claim I make has the modal operator taking wide scope over the universal quantifier: it is not possible that we can write down a short, useful algorithm that covers every medical problem. This is not to be confused with the plausible claim where the quantifier takes wide scope over the modal operator: for any arbitrary clinical problem, it is possible to articulate a short, useful algorithm on how to address it.

20. The question of goals also rightly falls silent on whether the treatment is life-sustaining or at the end of life, another poten-tial distraction from the correct conceptual analysis, as discussed earlier.

21. See Halevy and Brody, *supra* note 7, at 573. This policy is restricted to end of life cases only; an interesting issue I will not explore here is whether something similar but potentially less costly might be implemented for mundane cases of futility, such as refusing to give antibiotics for viral infections. The conceptual issues are the same; the difference is only in severity of potential harm and benefit.