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## MEDICAL FUTILITY OR PERSISTENT THERAPY? A DISPUTE OVER THE TERMS AND DEFINITIONS IN THE POLISH CONTEXT\*\*

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Słowa kluczowe: uporczywa terapia, medyczna daremność, nadzwyczajne procedury medyczne, pacjent terminalnie chory

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## Introduction

In contemporary society, medicine has become almost omnipotent, and the doctor, like the mythical Asclepius, has turned into a god who can withhold or at least delay death. When a person is in critical condition, the decision to hospitalize is made almost immediately. Conviction in the high effectiveness of resuscitation procedures results in the use of intensive care in severely ill patients, whose chances of survival are low. These actions may prolong life, but they may also prolong the agony, delaying death in an unnatural manner (Randall, Downie, 2010, p. 100). In some cases, these interventions may be qualified as persistent therapy.<sup>1</sup>

Due to the absence of bioethical and medical regulations, Polish experts in bioethics have started a discussion about the need to settle issues surrounding prolonging the lives of the terminally ill. This discussion is based on the dispute of whether the term “persistent therapy”, which is popular in Poland, should be rejected and replaced with the term “medical futility” in regulations. The dispute also encompasses the way of defining these terms. Until recently, “persistent therapy” has been the leading term in Polish bioethical and medical literature. Although many authors in Poland still refer to this term (Bazaliński, Marciniec, Sałacińska, Przybek-Mita, Więch, 2018; Budziński, 2016; Szeroczyńska, 2013; Wach, 2013), we

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<sup>1</sup> Although the term ‘over-zealous treatment’ derives from the Catholic Church’s moral teaching (I agree with the anonymous reviewer and I am aware of this context), it does not mean that this term is limited only to theological debate. Polish authors translate the term “uporczywa terapia” as “over-zealous treatment” (mainly theologians, but not limited to theologians; Machinek, 2015; Dowgiałło-Wnukiewicz, Kozera, Lech, Rymkiewicz, Michalik, 2019) or as “persistent therapy” (mainly medical professionals, but not limited to them; Krucińska, Saran, Czyżewski, 2018; Cebulska, Koźlak, Dybalski, 2019; Wach, 2020, pp.78–79). Moreover, some authors emphasize that the term „persistent therapy” is used as an equivalent to the term „medical futility” (Szewczyk, 2016; Suchorzewska, Basińska, Olejniczak, 2008). I translate the term „uporczywa terapia” as „persistent therapy” for two reasons. The first is that more and more Polish authors translate the term „uporczywa terapia” as „persistent therapy” instead of as „over-zealous treatment” in the medical literature. The second reason is more important. I think that the term „persistent therapy” more strongly emphasizes the role of the patient (his personal preferences) in making decisions on the continuation or discontinuation of treatment than the term „over-zealous treatment” (sometimes it is described as an „overtreatment” in the international literature), which focuses more on the physician’s role in decision making.

could observe a clear change in this respect in the past ten years. The term “medical futility” has become increasingly popular (Kübler, Siewiera, Durek, Kusza, Piechota, Szkulmowski, 2014; Siewiera, Kübler, 2015; Szabat, 2013, pp. 70–75; Szewczyk, 2009, pp. 303–307). Among other reasons, the need to change terms and introduce them into bioethical and medical documents is justified by the need for language standardisation and better international co-operation (Szewczyk, 2016). Participants in the discussion have raised various arguments for the rejection of the term “persistent therapy” and the introduction of the term “medical futility”. The dispute is fairly complex and entangled in various contexts: philosophical, medical, cultural, axiological, and religious. This article aims to present the most important aspects of the indicated dispute regarding the two terms and their definitions. I show that both positions can be reconciled under certain conditions. These conditions manifest themselves within a broad and a narrow semantic scope in the modified definition developed by the Polish Working Group on End-of-Life Ethics (PWG). In other words, I argue for modifying the PWG’s definition of persistent therapy. Moreover, I stress that the concept of persistent therapy of the PWG deserves attention because it is often quoted in the Polish literature on the subject (Pawlikowski, Muszala, Gajewski, Krajnik, 2021; Cebulska, Koźlak, Dybalski, 2019; Krucińska, Saran, Czyżewski, 2018), and, thus, may have an impact on the shaping of medical practice. I also assert that the term “medical futility” can be useful for bioethics only when its definition is limited to a narrow semantic scope.

### The definition of medical futility

Reflecting on the meaning of medical futility, it is worth noting that the word “futile” is derived from the Latin *futilis* (Jenal, Moreno, 2017, p. 103) and refers to actions or instruments that are inherently leaky and, therefore, ill-suited to achieving desired ends. The implication is that the use of leaky means will always be in vain as the leak is an intrinsic defect that will make failure inevitable (Rubin, 1998, p. 42). The ordinary meanings of futile include ineffective, useless, unsuccessful, and meritless (Robinson, 2010). Merriam-Webster’s Dictionary defines futility as “serving no useful purpose; completely ineffective” (Swetz, Burkle, Berge, Lanier, 2014, p. 943), and the Oxford English Dictionary defines the word “futile” defines as “leaky, vain,

failing of the desired end through intrinsic defect” (Schneiderman, Jecker, 2011, p. 20). According to Aghabarary and Nayeri, medical futility occurs when: (1) there is a goal, (2) there is an action or activity for achieving that goal, and (3) there is a virtual certainty that the action or the activity fails to achieve the goal (2016). The original meaning of the word “futile” indicates that a futile action is one that cannot achieve its goal, no matter how often it is repeated (Schneiderman, Jecker, Jonsen, 1990, p. 950).

Debates over futile care emerged in medical ethics in the late 1980s and early 1990s (Kearns, Gordijn, 2018, p. 12; Veatch, 2013, p. 12; Moratti, 2009, p. 369; Youngner, 2004, p. 1718). The idea was, as Wilkinson and Savulescu emphasise, that if physicians identified a particular treatment as futile, this would solve the problem of conflicts. Physicians had no obligation to provide futile therapy, and refusing to do so would, thus, not be paternalistic (Wilkinson, Savulescu, 2019, p. 22).<sup>2</sup> Over the next decade, many doctors and ethicists sought to define medical futility in a way that would be practically applicable.<sup>3</sup> For example, the most-cited and perhaps one of the broadest definitions of medical futility in the literature is the one provided by Schneiderman, Jecker, and Jonsen. Their definition refers to two parameters: a quantitative one and a qualitative one. Quantitatively, when doctors (based on their own experience, their colleagues’ experience, or empirical data) state that the therapy was useless in the last 100 cases, it can be deemed medically futile. Qualitatively, these authors suggest that any therapy that only sustains a state of permanent unconsciousness or fully prevents a patient from becoming independent of intensive medical care should be regarded as useless – which means futile – therapy (Schneiderman, Jecker, Jonsen, 1990, pp. 951–952; Schneiderman, Jecker, 2011, pp. 14–19). This understanding of the term has been heavily criticised (Burt, 2002; Lantos, 2006). Some authors have suggested that the concept of futility obscures many ambiguities and assumptions (Truog, Brett, Frader, 1992), while others have argued that the attempt to define futile treatment is itself futile (Brody,

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<sup>2</sup> It is worth noting that alternative terms for “medical futility” can be found in the literature: “non-beneficial treatment”, “not clinically appropriate”, “not medically indicated”, “clinical futility”, “medically inappropriate”, “medically inadvisable” and “potentially inappropriate” (Wilkinson, Savulescu, 2011).

<sup>3</sup> I do not discuss many concepts of medical futility; such a discussion is neither possible nor necessary. I only highlight a few important aspects of medical futility that will be helpful for the further discussion.

Halevy, 1995). The available definitions do not succeed in justifying the unilateral withholding of treatment. Furthermore, the quantitative and qualitative aspects of futility have often been challenging for clinicians to parse out because these aspects rely on value judgements on the quality of life as well as its role in assessing the virtue of longevity (Youngner, 1988). Some doctors have suggested that what a patient or surrogate defines as quality or quantity may differ from the clinician's perspective, and one can argue that qualitative futility is only met if a treatment does not allow patients to live their lives according to their goals, preferences, and values, which cannot be determined clinically or by how the last 100 patients responded in a given situation (Swetz, Burkle, Berge, Lanier, 2014, p. 944). Many studies have demonstrated that physicians disagree about quantitative and qualitative thresholds for futility (Curtis, Park, Krone, Pearlman, 1995; Van McCrary, Swanson, Youngner, Perkins, Winslade, 1994).<sup>4</sup>

In the literature, apart from the conception proposed by Schneiderman et al., two forms of futility can be distinguished: physiological and normative (Youngner, 1988; Veatch, 2013, p. 14). The term "futility" means that the goal for which the therapy is proposed is either unachievable or insufficiently worthwhile. In other words, the treatment is described as physiologically, factually futile (physiological aspect), or as evaluatively futile (normative aspect). In the first instance, a judgement that treatment is physiologically futile implies that it is not physiologically possible to achieve the goal, and the treatment is, thus, futile. In the second instance, a judgement that treatment is evaluatively futile implies that the goal itself would not be worth pursuing (Rubin, 1988, pp. 53–54). Rubin explains, "[f]rom a factual perspective, we can investigate whether the treatment in question is a possible means of achieving the designated goal. From an evaluative perspective, we can judge the worthiness of a designated goal and hence the worthiness of employing the treatment as a means of achieving it" (Rubin, 1998, p. 54).

The most narrowly defined type of medical futility is referred to as "physiological futility" (Vivas, Carpenter, 2020), wherein physicians do not make any evaluative assessment that a treatment's effect is not worthwhile. There is no normative (evaluative) disagreement; the physicians can ascertain physiological futility based on their clinical knowledge. The basis

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<sup>4</sup> I will present more critical opinions on this matter in the further discussion.

for refusing treatment is a scientific and empirical one: the treatment does not work.<sup>5</sup> This use of the term “futility” is true to the word’s core meaning (White, Pope, 2016, p. 72).

It cannot be ruled out that the crisis being experienced by the conceptions of medical futility today refers to the violation of methodological rigours. Such conceptions that take into account not only medical factors (physiological judgements) but also non-medical factors (valuing judgements) are not correct, and the error lies in the excessively broad interpretation of the definition of medical futility.<sup>6</sup> The semantic scope of many conceptions of this term has been enriched in an unauthorised manner. I presume that the consequences of this error are reflected in the terminological chaos that has arisen around defining medical futility in the last few years and in the impossibility of reaching a consensus on this matter. I also believe that the most reasonable approach to “rescuing” the understanding of medical futility is to return to its original meaning: forming a definition based on strictly medical factors. I believe this is a strong argument against the broader scope of the term. Therefore, I propose relating medical futility only to medical factors. I will return to the definition of medical futility later in the article (in the section titled “An attempt to overcome the stalemate – Modifying the PWG’s definition) because it requires some clarification. Now, this paper will turn its focus to the discussion surround the concept of persistent therapy.

### The Polish Working Group on End-of-Life Ethics’ definition and interpretation of persistent therapy

In Poland, the discussion concerning persistent therapy and medical futility began in 2008, when the PWG’s definition of persistent therapy was published. According to the PWG, persistent therapy is the use of medical procedures to maintain the life function of the terminally ill in a way that

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<sup>5</sup> Loretta Kopelman states that judgments about the futility of treatments in the contested cases must be supported by evidence and modified as the relevant evidence changes (Kopelman, 1995, p. 111).

<sup>6</sup> Definitions of medical futility that address factors beyond medical ones are inadequate in the sense that the scope of definiens becomes superior to the scope of definiendum.

prolongs their dying, introducing excessive suffering or violating their dignity (Bołoz, Krajnik 2008, p. 77).

The comment to the definition of persistent therapy proposed by PWG includes a suggestion that this definition reduces the use of „persistent” to denote medical procedures applied during the “dying” of a person regarded as “terminally ill” (Krajewski, 2008, p. 78). Moreover, “dying” should be understood as the terminal period of a disease, in which the patient’s condition continuously deteriorates, that leads to death within a short and predictable time. A terminally ill patient is considered to be a person on whom all therapeutic attempts to give a real chance for recovery or to inhibit the disease process have been exhausted. “Terminally ill” also applies to patients for whom none of such therapies exist. It is also stressed that a terminally ill person in a state of dying is subjected to procedures that, as a matter of fact, sustain the patient’s life and prolong his dying (Krajewski, 2008, p. 78). The next section delineates the purposes of limiting the definition.

According to the aforementioned comment, the limitation of the time to which persistent therapy refers is meant to help avoid difficult discussions on the possible acceleration of death. Additionally, the very statement that a terminally ill person is in a state of dying indicates that life-sustaining treatments would only prolong the dying process (Krajewski, 2008, 78). It is not known, however, why the PWG’s definition narrows the term “persistence” by establishing one criterion: excessive suffering. Moreover, it is not clear whether this means only physical suffering caused by pain or suffering in a broader context, such as suffering that can be interpreted as a group of complex unpleasant feelings resulting from various physical and mental factors. This complex group of feelings might be the result of both the ailments of the human body and external factors coming from the world that surrounds us (Suchorzewska, 2013). Because of limitations imposed on the definition of persistent therapy, scholars discussing this issue have doubts about the justifiability of narrowing the meaning of persistent therapy to only concern the terminally ill and dying persons (Orłowski, 2009). To resolve this question, we should begin by asking how “persistence” is interpreted.

## The meaning and scope of “persistence”

The adjective “persistent” derives from the noun “persistence” and expresses fierceness, tenacity, perseverance, endurance, and something that lasts continuously (Bartoszek, 2000, p. 268; Bartoszek, 2012). If something is persistent, we say that it cannot be suppressed, removed, or liquidated too easily or that it may be burdensome (Ferdynus, 2017, p. 125; Suchorzewska, Basińska, Olejniczak, 2008, p. 65). This term specifies the duration and intensification of a phenomenon. In medicine, permanent pain is often described as persistent (Aszyk, 2006, pp. 150–151). If it exceeds the intensity limit, it causes huge suffering that sometimes becomes unbearable (Ferdynus, 2017, p. 126). Thus, we can suppose that calling a therapy persistent means that the continuation of the therapy may not be completely ineffective and that it causes excessive suffering for the patient.<sup>7</sup> The patient may resign himself to another chemotherapy if previous ones failed to improve his health considerably and caused great suffering. As it remains possible that further chemotherapies could improve his health, we cannot state that the continuation of chemotherapy would only prolong the dying process (Chyrowicz, 2015, p. 312). This also applies to patients suffering from amyotrophic lateral sclerosis (ALS). We cannot determine whether the scope of “excessive suffering” encompasses situations in which patients suffering from ALS express a strong unwillingness to be permanently connected to a respirator. After being permanently connected to a respirator, ALS patients are not in the situation of a person in a state of dying, even though they are terminally ill (Andersen, Abrahams, Borasio, Carvalho de, Chio, Damme Van, Weber, 2012). Thus, it seems right to believe that if an ALS patient or any other patient is in a state of dying, the doctor should not focus on providing treatment, as patients in states of agony are not treated, but rather on making every effort to alleviate suffering and ensuring that the patient is supported until the end of the dying process (Ferdynus, 2018, p. 422). If starting, continuing, or ceasing a therapy becomes morally problematic, it is not because

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<sup>7</sup> At this point, I emphasise only the narrow nature of the definition proposed by PWG. I believe that even though the therapy may sometimes have little chance of success, the patient may find it persistent for some reasons (for example, due to excessive suffering). This position will become clearer when I propose a modification to PWG’s definition of persistent therapy.



the therapy proves completely ineffective from a medical perspective but because of the aforementioned cases. The examples mentioned here by no means exhaust the scope of patients for whom therapeutic persistence could be ascertained. The aim of the examples is only to remind us that the definition of persistent therapy proposed by the PWG does not encompass many cases of seriously ill patients because it is restricted only to cases of terminally ill and dying patients who excessively suffer.

### More arguments against persistent therapy

The debate about persistent therapy and medical futility in Poland has led to a polarisation of opinions. Some opponents of persistent therapy believe that the term is an anachronistic legal construction that expresses far-reaching mistrust towards the medical profession and its patients. Because of the correspondence between persistent therapy and medical futility, it has been suggested that the term “persistent therapy” – a popular expression in Poland – should be rejected (Szewczyk, 2016). It is important to note that the definition of persistent therapy that is being contested is the definition formulated by the PWG. Nevertheless, the postulate about the elimination of the term “persistent therapy” from Polish bioethical literature is not limited to the PWG’s definition but to the term “persistent therapy” in general. Arguments against “persistent therapy” are as follows:

1. Leaving the term “persistent therapy” in Polish bioethical literature leads to terminological chaos. Previously mentioned ambiguities in the term’s definition make it difficult or impossible for proper communication to happen between personnel in intensive care units and between the personnel and the patient, his family, or legal representative.
2. Years of discussion on medical futility show that the PWG’s definition of persistent therapy, which is similar to the definition of medical futility, is hardly a justifiable anachronism.
3. Remaining at the stage of definition means that the PWG’s definition can be accused of unjustified paternalism.
4. The inclusion of “dignity” in the definition of persistent therapy means that a doctor must decide whether the therapy they are considering violates this value. The presence of “dignity” in the

definition of persistent therapy becomes a source of fears concerning the excessive paternalism of doctors in the determination of persistence. Moreover, “dignity” as an ambiguous term makes it impossible to reach a consensus on the meaning of therapeutic persistence.

5. The PWG’s definition of persistent therapy burdens the doctor and the patient or his legal representative with the task of estimating the dying patient’s degree of suffering, which is a difficult, morally questionable, and highly subjective matter.
6. A negative aspect of the PWG’s definition is its complexity, which has been indicated by clinicians.
7. The relationship between the definition of persistent therapy and the teaching of the Catholic Church (CC) raises concerns that the adoption of the former violates the principles of a democratic state of law with a variety of worldviews.
8. The term “persistent therapy” has provincial connotations that limit its use to Poland, thereby hindering the discussion on the international bioethical and medical forum.
9. The fact that the term “persistent therapy” is commonly used in Polish literature is not a sufficient reason to leave this term in it.<sup>8</sup>

In connection with the aforementioned arguments, there is a postulate that “persistent therapy” should be replaced with “medical futility” in the bioethical and medical context. This opinion is shared by some scholars (Suchorzewska, 2016; Kübler, 2016).

### Potential replies to claims

When replying to the first claim (1), we could ask why using the term “persistent therapy” would contribute to bigger terminological chaos than using the term “medical futility”. A few years ago, the authors of the article “Medical futility and its challenges: a review study” analysed 89 publications about “medical futility” and found that it is a complex, ambiguous, subjective, case-specific, value-based, and goal-dependent concept that almost always involves some degree of uncertainty. In addition, the article’s overview of various definitions of medical futility has shown that

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<sup>8</sup> These arguments were collected by Szewczyk (2016).

the formation of such definitions is influenced by a wide range of factors: doctors' and patients' value systems; medical uses; social, cultural, and religious contexts; and individuals' emotions and personality traits. The authors of the study concluded that it is not possible to reach a consensus on the concept of medical futility because there is no objective and valid criterion that would serve as a basis for defining this term (Aghabarary and Nayeri, 2016). This opinion is shared by other authors discussing the issue of medical futility (Bosslet, Pope, Rubenfeld, Lo, Truog, Rushton, White, 2015; Nates, Nunnally, Kleinpell, Blosser, Goldner, Birriel, Sprung, 2016; Paris, Hawkins, 2015, p. 51). Therefore, many scholars argue that medical futility should be defined based on the unique condition of each patient (Heland, 2006; Jox, Schaidler, Marckmann, Borasio, 2012).

Recent research, which has indicated that medical personnel properly understand the term "persistent therapy", speaks against the opinion that leaving the term "persistent therapy" in Polish bioethical literature causes terminological chaos or makes communication between the doctor and the patient impossible (Bazaliński, Marciniec, Sałacińska, Przybek-Mita, Więch, 2018). While it is true that authors often use the term "persistent therapy" in Polish literature, definitions of the term do not differ widely. The PWG's definition is only one of a limited number of examples, although its definition is commented upon most frequently.

The second claim (2) could be valid if there were as many definitions of persistent therapy in Polish scholarship as there are definitions of medical futility in English scholarship. Since the publication of the PWG's definition in 2008, no new definition of persistent therapy has appeared in Poland. Thus, transposing this opinion onto persistent therapy is wrong despite the seemingly valid opinion about the impossibility of agreeing on the term "medical futility". While it seems premature to exclude the possibility of reaching such a consensus someday, we also cannot state that an agreement will ever be reached. In addition, the second claim could be valid if we assumed that medical futility and persistent therapy are identical terms. In fact, some authors regard these terms as identical (Szewczyk, 2016). While it can be said that these authors narrow the PWG's definition of the meaning of medical futility, we cannot think that such a narrow interpretation of persistence is legitimated. I think that medical futility should not be identified with persistent therapy from a methodological viewpoint. This is an issue of key importance that I will expand upon in the next point.

The next two claims (3 and 4) refer to unjustified or excessive paternalism and the term “dignity”. We agree with the statement that the term “dignity” has many facets, which means that it is ambiguous and, therefore, unclear (Lombard, 2018, pp. 98–100; Napier, 2020, pp. 83–105). There are, however, also opinions such as the one expressed by Immanuel Kant, who argued that dignity has a concrete and absolute character. According to Kant, dignity is a value that has no price and no equivalent for which it could be exchanged. Kant writes: “In the kingdom of ends everything has either a price or a dignity. What has a price can be replaced by something else as its equivalent; what on the other hand is above all price and therefore admits of no equivalent has a dignity [...]; that which constitutes the condition under which alone something can be an end in itself has not merely a relative worth, that is, a price, but an inner worth, that is, dignity” (Kant, 2012, pp. 434–435).<sup>9</sup>

If, for example, we assume that dignity is an irreducible and unlosable value that cannot be granted or taken away by valuing subjects (other persons), it could not be violated in any way. Therefore, the claim of unjustified or excessive paternalism could be annulled, at least from a theoretical viewpoint (from the definition level). If, however, dignity was identified with autonomy, the claim of unjustified paternalism could be legitimate. The PWG’s definition of persistent therapy indicates that the decision on the discontinuation of treatment is made by the doctor. However, the problem lies in the fact that members of the PWG do not clarify the term “dignity” used in the definition (Krajewski, 2008). It undoubtedly forms a weak link in this definition. It does not facilitate the discussion either, because it inevitably leads to the valuing of human life.

However, we must acknowledge that among conceptions of medical futility there are also a few definitions with a tendency to value life. One such postulate appears, among others, in the conception of medical futility proposed by Schneiderman et al. (1990).<sup>10</sup> In the Polish context, similar understandings are voiced by Kübler et al. (2014, p. 230). They stress that a patient benefits from a therapy only when it allows him to survive and be released from the intensive care unit. If this condition is not fulfilled, we can regard such therapy as medically futile. Some ethicists find such

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<sup>9</sup> See also: Kerstein (2019).

<sup>10</sup> See also: Schneiderman (2011).

criteria confusing and question whether it can be claimed that someone who is dependent on intensive care even for a while cannot live a relatively valuable life (Macauley, 2018). The critics of the qualitative approach in the determination of medical futility stress that physically and mentally disabled persons can obtain much satisfaction in their life, although others may not recognise the potential benefits associated with the therapy undertaken by these patients (White, Pope, 2016). The quantitative criterion is criticised mainly for three reasons: (1) it is unclear at which point the percentage threshold should be fixed, (2) using measurements taken from research on the population level is imprecise, and (3) disease and mortality rates are often based on uncertain predictions (White, Pope, 2016, p. 73).<sup>11</sup> Others add that no two identical cases occur in medicine and argue that statistics may prove to be incorrect (Chyrowicz, 2015, p. 317).

The next two claims (5 and 6) can be addressed jointly. Although some clinicians say that the PWG's definition of persistent therapy is burdened with a certain "degree of complexity", they do not explain where this difficulty lies (Siewiera, Kübler, 2015, pp. 9–10). It is possible that estimating the level of suffering of a dying patient may prove complicated (claim 6). Although the PWG's definition specifies excessive suffering as the main criterion for therapeutic persistence, some conceptions of medical futility also refer to suffering that requires estimation (Salter, 2020; Aghabarary, Nayeri, 2016; Robinson, 2010; Sibbald, Downar, Hawryluck, 2007). It is, however, beyond doubt and dispute that the estimation of suffering is a subjective matter and, therefore, may arouse moral doubts: To what extent is therapeutic persistence related to suffering that is actually persistent? I think that the verification of such situations is not always possible for external observers (even for doctors). Sometimes, this question can be resolved only by the patient (Cassell, 2016). But does the patient's estimation of his own suffering not argue in favour of the fact that he possesses autonomy?

The seventh claim suggests that the PWG's definition of persistent therapy is connected with the CC's moral teachings, which raises concerns that the adoption of this definition will violate the principles of a democratic state of law with a variety of worldviews. To verify the correctness of this claim, we must refer to the content of a representative document in this

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<sup>11</sup> Other authors identify certain problems connected with the estimation of medical futility: Sørensen and Andersen (2019).

respect. The Catechism of the Catholic Church (CCC) seems to fulfil such a role. It reads: “Discontinuing medical procedures that are burdensome, dangerous, extraordinary, or disproportionate to the expected outcomes can be legitimate; it is the refusal of »persistent therapy«. Here, one does not will to cause death; one’s inability to impede it is merely accepted. The decisions should be made by the patient if he is competent and able or, if not, by those legally entitled to act for the patient, whose reasonable will and legitimate interests must always be respected” (Catechism of the Catholic Church, no. 2278).<sup>12</sup>

If we consider this document to be representative with regard to the scope of “persistent therapy”, we must admit again that the PWG’s definition of persistent therapy is close to the definition of medical futility. Thus, we must also assume that the interpretation of “therapeutic persistence” by the PWG’s members deviates from the official teachings of the CC. The scope of the definition contained in the CCC is incomparably broader than in the PWG’s definition. Therefore, the impact of the CC’s teachings on the emergence of this definition can be regarded as minor or even non-existent.

I fully agree with the last claims (8 and 9). With regard to the first claim (8), critics are right to say that the term “persistent therapy” is present mainly in Polish literature, thereby hindering the discussion with experts on the international bioethical and medical forum.<sup>13</sup> The problem is, however, that Polish ethicists and critics have not joined the international discussion on medical futility until now. This article may serve as a response to the claim quoted here, which can be labelled as provincialism.

The last claim (9) is fully justified. I agree that the popularity of a term in literature – in this specific case, “persistent therapy” – is not a sufficient argument for leaving the term there. However, I think that there is a deeper reason for which the term “persistent therapy” can still be useful.

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<sup>12</sup> I am aware that the English version of the Catechism of Catholic Church (CCC) contains the term “over-zealous treatment” and the Polish version of the CCC contains the term “uporczywa terapia”. According to earlier remarks and for consistency of my argumentation I use here the term “persistent therapy”.

<sup>13</sup> It must be stress the terms “persistence” and “persistent therapy” are not entirely alien; they appear in international literature (Groarke, 2018; Paris, Cummings, Moore, 2019; Hoehn, 2019), although they are rarely discussed.

## An attempt to overcome the stalemate – Modifying the PWG’s definition

The PWG’s definition of persistent therapy involves many limitations. Its main shortcoming is the excessive narrowness of its scope, which does not include many real case studies of occurrences in intensive care units (Ferdynus, 2017, pp. 121–127). Such a definition of persistent therapy is, thus, not useful in medicine. Therefore, I propose modifying PWG’s definition of persistent therapy as follows:

Persistent therapy is the application of extraordinary or causally ineffective medical procedures to sustain the life of a terminally ill patient.

Wording the definition in this way does not narrow persistent therapy to only terminally ill persons who are considered to be in the state of dying. In this definition, a terminally ill person can be interpreted as a patient who will die within twelve months or less (Szewczyk, 2009, p. 291; Ferdynus, 2017, p. 122),<sup>14</sup> and the expert in the ascertainment of the terminal state is the physician.

This modified version of the PWG’s definition also states that persistent therapy is related to the application of extraordinary medical procedures.<sup>15</sup> This extraordinariness is determined by various aspects that directly concern the patient: (a) physical, (b) emotional (psychological), (c) axiological, and (d) economic.<sup>16</sup> The last aspect does not suggest that human life should be subject to economic calculations, but that costs related to the application of a therapy cannot be completely ignored (Hughes, 2020). Thus, regarding the physical aspect (a), the recognition of a therapy as persistent may involve pain that is difficult to eliminate or, more broadly, excessive suffering. With respect to the emotional aspect (b), persistence may involve fear or a strong reluctance to undergo the therapy (e.g., an ALS patient who no longer wishes to be permanently connected to a respirator). The patient’s

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<sup>14</sup> The definition of “terminally ill” in Poland is different from the definition used in current medical practice, at least in the US. In the US, it is six months or less (Macauley, 2018, p. 72; Smith, Glare, 2016, p. 172).

<sup>15</sup> The term “extraordinary” is included in the definition because it is often used in Polish bioethical literature quoted in this article. However, we can wonder whether the term “extraordinary” could be replaced with the term „burdensome”.

<sup>16</sup> The highlighted aspects are established on the basis of the following publication: Pellegrino (2000).

subjective preferences regarding values and beliefs (e.g., moral and religious ones; Pellegrino, 2005) can be regarded as persistent in the axiological sense (c). Persistence in an economic sense (d) will involve significant effort to acquire a medical device or costs that prove burdensome for the patient (or their family; Ferdynus, 2017, p. 143). I do not claim that this is the only set of criteria that allows us to regard a therapy as persistent. However, I assert that the scope of therapeutic persistence is not limited to the “excessive suffering” that the PWG indicates in its definition.

Referring to medical procedures as “causally inefficacious” means that a therapeutic action undertaken by a physician cannot achieve the intended physiological goal, and, thus, it is medically futile (Bosslet, Pope, Rubinfeld, Lo, Truog, Rushton, White, 2015; Waisel, Trough, 1995, p. 306). We can also say that if the treatment cannot restore irreversibly lost functions of the body (e.g., a patient has irreversibly lost their capacity to breathe independently) or cannot stop the progression of the disease (e.g., the ineffectiveness of aspirin in managing cancer, of defibrillation on asystole, or of conventional cardiopulmonary resuscitation for a patient with myocardial rupture; Aghabarary and Nayeri, 2016), then it is medically futile. I agree with the opinion of Waisel and Trough, who emphasise the following: “If a treatment cannot achieve a physiologic objective, and thus, no benefit is being offered to the patient, then a physician is not obligated to offer this treatment. Physiologic futility appears to have the least risk for unilaterally imposed physician value judgments. Admittedly, problems may occur in determining precise definitions of physiologic functions (such as circulation and ventilation), but these are more technical in nature and do not involve substantial value judgments” (Waisel, Trough, 1995, p. 306).<sup>17</sup>

I think that physicians as professionals can ascertain physiological futility based on their current clinical knowledge. Moreover, the basis for refusing treatment is a scientific and empirical one: the therapy either works or it does not. I do not depreciate statistical data in clinical practice – data can help determine medical management. However, I argue that the

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<sup>17</sup> Waisel and Trough also emphasise that “The adoption of physiologic futility cannot substantially change practices, if the decision to halt therapy must wait until the physiologic objective cannot be achieved, then the patient, for all practical purposes, will be dead nearly immediately after the declaration of physiologic futility. This strength of physiologic futility minimises the chance of a physician error in quantitative assessment limiting the length of life.” (Waisel, Trough, 1995, p. 307).



understanding of medical futility presented above avoids unnecessary questions such as the following: Is an effect so small that it is not worth pursuing? How small should the chance of successful treatment be to qualify as futile (i.e., one in a hundred, a thousand, a million; Wilkinson, Savulescu, 2019, p. 27)? Furthermore, from a methodological point of view, it seems right to ascertain medical futility only with regard to strictly medical factors (i.e., to consider the physiological aspect). Only with such an interpretation of medical futility can I agree with the authors of “Principles of biomedical ethics” that doctors are not obliged to initiate or continue such therapy (Beauchamp, Childress, 2012, p. 169), even when the patient, their family, or their representative exerts strong pressure in this respect (Caplan, 2012). The determination of medical futility is a medical decision; therefore, it falls within the competence of the doctor (Chańska, 2009, p. 212), not an ethicist, the patient, their family, or their representative (Terra, Powell, 2012, p. 104). Furthermore, the scholarship on the subject emphasises that the continuation of medical futility is a medical error (Kübler, Siewiera, Durek, Kusza, Piechota, Szkulmowski 2014, p. 230).

Considering what has been said so far, we can suppose that persistent therapy should be understood within both a narrow and a broad semantic scope. In other words, I maintain that “persistent therapy” (as a single term) should be given with dual interpretations. In the broad sense, the content of persistent therapy may overlap with the modified version of the PWG’s definition as presented in this paper (or with a similar version). In the narrow sense, persistent therapy is a form of medical futility (i.e., causally inefficacious therapy). The essential difference between the broad and narrow understanding of persistent therapy is that in the former, apart from medical factors, the patient’s (or surrogate’s) subjective preferences take precedence.<sup>18</sup> Moreover, medical futility is reduced only to strictly medical factors, and the expert in ascertaining medical futility (or persistent therapy in the narrow sense) is the physician, not the patient. It seems that we can consider leaving both terms – “persistent therapy” and “medical futility”

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<sup>18</sup> It must be stressed that while the persistent therapy in the narrow sense (medical futility) relies on causal links and efficacy, persistent therapy in the broad sense involves evaluative judgements on the relationship between the burdens and benefits of medical intervention.

– to bioethical and medical regulations only if the indicated methodological reservations are considered.

## Concluding remarks

As indicated at the beginning, the focus of the analyses was on the dispute surrounding definitions and terms. This means that many other issues have been intentionally excluded because their analysis would largely go beyond the limits of this paper. Finally, I would like to add a few further remarks.

First, a large proportion of the conflicts emerging in intensive care units relates to the commencement, continuation, or discontinuation of persistent therapy. On the one hand, patients or their representatives sometimes attempt to persuade doctors to apply persistent therapy within a narrower scope (i.e., medical futility). However, as I have demonstrated, a patient's demands are completely unjustified when "persistent therapy" is understood in a narrow sense, and the patient has no right to demand the continuation or commencement of medical futility from the doctor. The expert in deciding on such a therapy is the doctor (or the medical team). On the other hand, the situation is different when a therapy is considered to be persistent within a broader scope. With regard to the ascertainment of discontinuing such therapy, patients have the right to demand that their subjective decisions be respected. I am far from arguing that the ascertainment of persistence within both scopes is simple and that each doctor discontinuing therapy is free of doubts. However, I wish to reiterate the aforementioned opinion that no two identical cases in medicine exist, and statistics may prove to be incorrect. Therefore, we must agree with those who believe that the patient's individual condition should be taken into account in any decision on discontinuing therapy. Nevertheless, doctors require criteria to decide on discontinuation, even if these criteria are not unequivocal and individual cases are subject to discussion. Second, it seems important to solve all conflicts between the patient and the physician through dialogue (Quill, Holloway, 2012; Burkle, Benson, 2012; Brody, 1997, p. 14). Building a warm relationship based on openness and trust between the doctor (or medical personnel) and the patient (or family or representative) may prove to be a key issue in making a decision on discontinuing therapy (McAndrew, Hardin, 2020; Andersen, Abrahams, Borasio, Carvalho de, Chio, Damme Van, Weber, 2012). Third, palliative care as an

alternative to aggressive treatment still seems to be mentioned too rarely in the discussion on persistent therapy and medical futility (Courtwright, 2012). Even though therapy may prove futile for a patient, palliative care is never futile (Jenal, Moreno, 2017, p. 114; Schneiderman, 2011, p. 130).

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## MEDICAL FUTILITY OR PERSISTENT THERAPY? A DISPUTE OVER THE TERMS AND DEFINITIONS IN THE POLISH CONTEXT

### Summary

This article presents the current discussion around the terms “medical futility” and “persistent therapy” and their definitions. This discussion is based on the dispute of whether the term “persistent therapy” should be rejected and replaced with the term “medical futility” in Polish bioethical and medical regulations. The dispute started after the Polish Working Group on End-of-Life Ethics (PWG) had published its definition of persistent therapy in 2008. To settle the dispute, the author proposes a modified version of the PWG’s definition of persistent therapy that combines persistence and futility. He argues that persistent therapy is the application of extraordinary or causally inefficacious medical procedures to sustain the life of a terminally ill patient. He also asserts that medical futility can be useful for bioethics only when its definition is limited to medical factors.