Mediating Disputes about Medical Futility
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In a recent issue of Cambridge Quarterly of Healthcare Ethics, Howard Brody and Lawrence Schneiderman offer contrasting opinions about how to apply the concept of “futility” in medicine. Brody holds that “futility cases” are those in which it is reasonably certain that a given intervention “will not work” when applied for the purpose of attaining a specific clinical goal. To determine which actions are futile, Brody prescribes a division of labor. Patients (or patient surrogates) are charged with choosing the goals of treatment while physicians are charged with determining whether specific treatments will be effective in achieving these goals. Though physicians do not choose specific goals, Brody thinks they have a prerogative to decide whether they can, in good conscience, aid in the achievement of specific patient goals. Let us use “positive validation” to denote choosing between alternative goals and “negative validation” to denote choices about whether one will assist in the pursuit of particular goals. Brody’s position is essentially that patients are positive validators and that physicians are negative validators. Brody concludes that treatments that are effective in achieving patients’ goals are not futile—even when physicians’ personal or professional moral commitments prevent them from offering these treatments for the given purpose. “Futility” applies only where interventions won’t “promote a goal that both agree is desirable.”

Schneiderman disagrees, holding that physicians should have a role in positive validation as well as prognostication. In Schneiderman’s view, the medical profession has articulated appropriate general goals (such as relief from suffering). Specific clinical goals are acceptable only when they conform to these general goals. Schneiderman concludes that treatments that cannot succeed in achieving medicine’s appropriate goals are futile, even when they work for patients’ peculiar, nonmedical purposes.

Differences between Brody and Schneiderman arise in the context of a debate concerning whether cases such as Helga Wanglie and Baby K count as futility cases. Brody thinks these are not futility cases because he identifies the clinical goals in these cases as the goals that were selected by patients’
surrogates. Schneiderman thinks these are, indeed, futility cases because he identifies the goals in these cases with the general goals of medicine.

I propose in this paper that Brody and Schneiderman have both missed the boat on futility. They err because:

1) They misrepresent their disagreement as a conceptual issue about futility. To the contrary, I maintain that the concept of futility is straightforward and rarely misunderstood. Here, as elsewhere in the beleaguered history of debates about medical futility, the real issue hinges on differing accounts of medical authority.

2) Both thinkers fail to identify the ultimate locus of authority in clinical medicine. Brody here writes as if it resides mostly with patients. Schneiderman holds that it resides mostly with professionals. Working from the philosophy of Josiah Royce, I will argue that it resides in a “greater medical community” that includes all persons (professionals, patients, potential patients, etc.) who loyally promote the ideals of medicine.

Interestingly, in the past Brody has shown sympathy for both Schneiderman’s view of professional authority and (indirectly) for my own view that authority resides in the greater medical community. My overall impression is that Brody generally occupies a position very close to mine concerning patient-physician relationships. However, his tendencies toward deontological liberalism prevent him from fully embracing the social ideals of the greater medical community. With respect to the current debate between Brody and Schneiderman, I side with Schneiderman. The Baby K and Helga Wanglie cases are (at least potentially) futility cases.

The Concept of Futility

The concept of futility applies whenever three conditions are satisfied. First, there is a goal. Second, there is an action or activity aimed at achieving this goal. Third, there is virtual certainty that the action will fail. In these circumstances, we say that the action in question is futile with respect to the goal in question. To my knowledge, no one has seriously questioned or deviated from this basic understanding of futility. It is simple. It is clear.

Debates about futility are debates about specific interpretations of the basic concept. These debates generally hinge on one or both of the following:

1) Parties in the debate disagree about the goal or goals that should serve as a standard for determinations of futility; or

2) Parties in the debate disagree about what counts as “virtual certainty” that an action will fail to achieve a goal.

In this paper the concern will be mostly for the first of the above sources of debate.

Schneiderman and Jecker (among others) have addressed the second issue. They suggest that a treatment is quantitatively futile when it has not worked in the last 100 similar cases. Several difficulties seem to inher in such standardized, quantitative approaches to the question of “virtual certainty.” First, our willingness to discount unlikely strategies varies with the desirability of the goal we hope to achieve. For instance, a moneymaking strategy that offers only a 1-in-1,000 chance of earning a dollar (and no chance of earning more) is considered futile; one that offers the same chance of producing a million dollars is not. A likely counter response to this criticism would be to claim that I have conflated futility and
utility. This response is plausible, since the concept of ineffectiveness (from which the concept of futility largely derives) is nonevaluative with respect to the desirability of goals. Resolving this difficulty seems to hinge on whether we want to define futility in terms of its use in natural language or strictly as a form of ineffectiveness.\(^6\) In any case, I must admit that here we have a genuine conceptual issue about futility, and one that I am quite content to defer.

A second problem with Schneiderman and Jecker’s notion of quantitative futility is that it is difficult to determine which cases should count as the last 100 similar cases. Since each patient is different, it is difficult to calculate precise probabilities that a given treatment will succeed for a particular patient.\(^7\)

A final problem with quantitative accounts of futility arises from variations in risk tolerance. Like thresholds for significance tests, statistical thresholds for what should count as futile are not discovered. They are chosen. A conception of an acceptable risk of failure (which is a function of beliefs about the good life) is one of the values that affect the choice of a futility threshold. Thus conceptions of quantitative futility are not divorced from conceptions of the good. This connection detracts from the usefulness of medical futility as a rationale for unilateral medical futility judgments, since such use is apt to reflect the view that futility can be an objective “medical judgment” that somehow falls outside the realm of patients’ values.\(^8\)

**Brody and Schneiderman on the Goals of Medicine**

In debates about futility, participants often comment on some treatment, \(X\), using expressions such as “\(X\) is futile.” Such expressions are useful as a shorthand way of saying “\(X\) is futile with respect to \(Y\),” where \(Y\) is a mutually recognized goal. However, saying “\(X\) is futile” obfuscates the situation when the debate is really about \(Y\). On such occasions, participants occasionally think they are debating the nature of futility when in fact they are debating about morally appropriate goals. At times, Brody and Schneiderman seem to fall into this trap.

Brody proposes that the defenders of the concept of futility “stop providing ammunition to their opponents by repeatedly citing as ‘futility cases’ two cases that properly understood have nothing to do with futility as such—Helga Wanglie and Baby K.”\(^9\) This proposal seems to contain a claim that certain thinkers—Schneiderman in particular—are confused about the concept of futility.

But Schneiderman suffers no such confusion. When he says that mechanical ventilation (and other treatments) for Helga Wanglie were futile, Schneiderman identifies each of the three elements of futility. There is a goal: benefit for the patient in the form of personal fulfillment or relief from suffering. There is an action aimed at achieving this goal: mechanical ventilation, for instance. And there is virtual certainty that the goal will not be achieved. Schneiderman is correct if he states that treatments for Helga Wanglie were futile with respect to Ms. Wanglie’s sense of personal fulfillment or relief from suffering. But Schneiderman never makes precisely that statement. Instead, he says that medical treatments for Helga Wanglie were futile. Period. As if there were only one operative or legitimate goal.

Brody is similarly dogmatic. He takes issue with Schneiderman because he thinks that the real goal of treatment was prolonging Wanglie’s biological life. Like Schneiderman, Brody focuses on only one operative goal. Their dis-
agreement, then, is over the appropriate goals in this case, not over the concept of futility. Once again, Brody thinks that patients (or patients’ surrogates) should positively validate clinical goals. Since the Wanglie family seemed to suffer no illusions about Ms. Wanglie’s permanent loss of consciousness and inability to suffer, it seems clear that their aim in demanding ongoing life support was to prolong her biological existence. If this was their choice, then for Brody it was the goal of treatment. Schneiderman, on the other hand, thinks that certain basic goals of medicine apply (or should apply) in all cases and that a legitimate goal in any clinical circumstance must conform to these basic goals. Thus he identifies a different goal for Wanglie and holds that mere prolongation of biological life is inappropriate (hence not a goal at all).

My position is that both thinkers have identified legitimate goals. Brody is correct in holding that prolongation of life is a valid goal—at least prima facie—if that is what a patient or patient’s valid surrogate wants. However, Schneiderman is also right to declare that benefit to patients, in the form of some conscious fulfillment, is (or should be) a universal goal of all medical treatments and the treatments that do not provide this benefit are futile in an important way. The treatment for Wanglie, then, is not futile and it is futile. It is not futile with respect to the first goal. It is futile with respect to the second.

Clarifying the issue by clarifying goals and by identifying which goals are attainable can be a great benefit for clinicians and patients alike. As any clinical ethicist can attest, this strategy is the cornerstone of ethics consultation. After clarifying goals (with caregivers and with patients and families) and determining the likely results of possible interventions, decisions about withholding or withdrawing care begin with the following question, For which, if any, goals is the proposed treatment futile? Treatments that are futile with respect to all of the important goals should clearly be withheld or withdrawn. However, when treatments are futile for one goal but not another, then other factors warrant consideration. What is the relative importance of competing goals? What is the overall likelihood of achieving the most important goals? What are the burdens of the treatment?

These are questions that should have been breached in the Wanglie case. However, the court addressed a different question: Who should be making proxy decision for Ms. Wanglie? The Minnesota court probably answered this question correctly. Mr. Wanglie was the most suitable proxy. However, there is a different (though often assumed to be equivalent) question that was not settled in the Wanglie case: Where is the proper locus of authority for decisions about withdrawing or continuing treatments such as Ms. Wanglie’s? When the court ruled for her husband as the proxy, it was taken by many to mean that Mr. Wanglie was the sole legitimate authority for such decisions. This interpretation of Wanglie would vindicate Brody’s claim that patients or patient surrogates should be the ones who positively validate clinical goals. I will argue against this line of reasoning.

Authority for the Goals of Medicine

The patient–physician relationship is the centerpiece of clinical medicine. Patients go to physicians or other clinicians when their life plans have been disrupted by what they perceive as medical problems. Patients do not seek out politicians, lawyers, ethicists, radiologists, laboratory technicians, insur-
Responses and Dialogue

ance agents, healthcare administrators, or public interest groups for medical care. These latter parties are useful for patients only insofar as they support the patient–physician relationship.

Yet the support provided by these nonclinical groups is immense. Clinical medicine, as it is now practiced, would be impossible without their help. Medicine is an inherently social activity, grounded in precedents and moral norms that reflect wide social consensus and deeply ingrained cultural patterns. All who contribute to the norms, the practices, and the institutions of clinical medicine are real or potential members of a collective enterprise. This “concerned public” includes all persons with an interest in and commitment to the provision of ethical healthcare. The concerned public is medicine’s ultimate governing body, and the collective enterprise that it strives to define and enact is the ideal for what I call the “greater medical community.”

The concept of a greater medical community (GMC) arises from the moral idealism of Josiah Royce. Royce holds that moral communities are pre-requisites for moral life. Natural moral communities are required for character formation and ideal moral communities provide the telos for these natural communities. Loyalty is conceived as the willing, practical, and thoroughgoing devotion to the interests of a moral community. For Royce, loyalty to an inclusive moral community (the “great community”) is the highest moral obligation as well as the ultimate source of personal fulfillment. The greater medical community is an ideal community that serves the great community by cultivating excellence in healthcare.

Membership in the greater medical community is open to all who share its ideals. Members contribute in diverse ways: (1) through critical examination, interpretation, and revision of the goals, norms, and practices that govern the provision of healthcare; (2) through public support for medical education, research, and outreach; (3) through personal and professional commitments to support the ideals of medicine; and (4) by interpreting personal illnesses as medical problems and seeking the help of medical professionals. The GMC provides no certificate of membership and charges no formal dues. It has no headquarters, no officials, and no registry. Nevertheless, it is the ultimate locus of authority in clinical medicine.

A philosophy of medicine founded on the notion of a Roycean community of inquiry such as the GMC is not consistent with naive communitarianism. Whereas naive communitarian theories appeal to the rule of the majority by invoking cultural custom and consensus as final moral authorities, the GMC is authoritative only insofar as its ideals are fashioned in accordance with a sound public philosophy. Moral norms derived from custom and consensus are important—vitally so—but these norms are not compelling until they have been adequately defended. An adequate defense is predicated on an adequate public philosophy. I have articulated many of the basic features of such a public philosophy in The Loyal Physician and will cover only a few important highlights in this essay.

A sound philosophy of medicine requires an account of the human goods that medicine helps to achieve. Such an account revolves around a general theory of human goods or human flourishing. Hence the proper goals of medicine are a subset of society’s proper goals and, as previously noted, the GMC is best viewed as a moral subcommunity. Several cogent descriptions of the goals of medicine have greatly advanced the endeavor of articulating the ideals of the GMC (though much work remains to be done).
Responses and Dialogue

Not all thinkers agree with the notion that public morality should depend on an account of human goods. A very influential school of thought insists that it should be based on procedural principles that are neutral with respect to theories of the good. Michael Sandel designates this view as “deontological liberalism.” Since it is impossible to defend procedural principles apart from some kind of notion of the goods that given procedures seek to achieve, deontological liberals invoke (either implicitly or explicitly) various “thin theories” of the good. Such thin theories are too devoid of content to justify a coherent set of social or medical goals, but deontological liberals think they provide sufficient backing for their procedural principles (often formulated, as per Rawls, as principles of justice). These procedural principles, in turn, are portrayed as the fundamental principles of public morality. Theories of the good (i.e., theories with more content than their thin theories) are, according to deontological liberals, essentially private matters, pursued freely and independently by individuals and groups (just as long as these pursuits do not run afoul of the procedural principles).

Deontological liberalism fails because its proponents’ various thin theories are not sufficient for the task of justifying comprehensive, authoritative theories of justice. These thinkers generally fall prey to one or both of the following difficulties: (1) they surreptitiously import their own thick theories of the good into their procedural principles; or (2) they produce overly formal procedural principles that so vastly underdetermine public policy that they provide no genuine basis for mediating social conflicts. The net result, in either case, is a political climate dominated by shrill advocacy devoid of reasoned argument. Individuals in such a community tend to interpret their own central values as preconditions for civil society while interpreting others’ values as merely contingent, personal convictions about the good life.

Brody’s view of medical decision-making reflects the deontological framework. Procedural justice demands that individuals have access to medical care, since illness and suffering, broadly conceived, are bad for just about everyone. But specific interpretations of illness and suffering are private matters. Thus the deontological liberal will expect physicians to advise on only a limited aspect of illness—the part that pertains to diseases, technical interventions, and the likelihood that the latter will effectively mitigate or alleviate the former. Physicians are not to advise about appropriate aims of treatment in any given situation because these aims are personal matters for patients and their loved ones.

But what if the patient’s values are inextricably bound with public values? What if the patient’s personal identity contains, or should contain, a significant element of civic devotion? Perhaps then she would want, and be obligated to support, clinical goals that are consistent with civic goals. One way that Roycean idealism differs from deontological liberalism is that it is far more impressed by the convergence between civic responsibility and personal fulfillment. Brody’s account of the division of labor in clinical goal setting is unacceptable for the Roycean idealist just because it underestimates the degree to which patients and physicians share in the life of the greater medical community. Because Brody fails to recognize the mediating influence of the GMC, he perceives patient values as radically independent from physician values and insists on the priority of the former in medical decision-making.

Schneiderman, on the other hand, goes too far on behalf of physicians’ values. He advocates that physicians
(as a group) should be responsible for formulating the goals of medicine and that individual physicians should bear primary responsibility for interpreting these goals in clinical scenarios. Though it is true that the experience and expertise of physicians are a great help in these matters, clinical goods are not so remote or esoteric that non-physicians cannot skillfully interpret them. Patient input is essential because even in a harmonious, nonoppressive society, manifestations of civic virtue will be as various and variable as the personalities and unique contributions of its citizens.

Schneiderman also errs by endorsing a naively communitarian view insofar as (1) he seems to accept Hippocratic ideals because they are traditional or conventional and (2) he relies almost wholly on consensus as a means of interpreting or revising medicine’s tradition. Of course, traditions are important, as they are the embodiments of public philosophies. Consensus is important because it reflects public conscience. But there are bad public philosophies, producing bad traditions and faulty consciences. Once again, a defensible public philosophy is the only defensible basis for tradition and the only acceptable justification for public sentiment. It is not unusual for an individual or small group to stand alone against an oppressive tradition or a tyrannical majority.

Brody and Schneiderman occupy differing poles of a spectrum of views concerning the power differential between patients and physicians. In the end, however, they fall prey to a similar error. They fail to critically engage the goals of medicine. As Sandel claims, make a similar mistake; both try to avoid passing judgment on the content of the ends that rights promote. But these are not the only alternatives. A third possibility, more plausible in my view, is that rights depend for their justification on the moral importance of the ends they serve.

Roycean idealism opts for the third approach, occupying a middle position between liberal and naive communitarian extremes by rejecting their common premise. The GMC doesn’t pretend to refrain from judgment on substantive moral claims. Its purpose is to evaluate, articulate, defend, and promote the goals of medicine. When the interpretation of these goals is in dispute, the GMC is a mediator. It mediates disputes by providing the conceptual apparatus for social organizations (such as hospitals, hospital ethics committees, professional organizations, patient groups, community health programs, legislatures, etc.) and for individuals who are called to deliberate over these disputes.

Where does this leave medicine’s “centerpiece,” the patient–physician relationship? Right where it belongs—free from the tyranny of absolute control by either party. As Royce argues, any dyadic relationship is dangerously unstable and can be effective only insofar as it comes under the mediation of common ideals or a just governing authority. The GMC is the proper source of these ideals and it provides the theoretical foundation for just government. It establishes the patient–physician relationship as the normal locus of medical deliberation, supporting a model of shared decisionmaking.

Liberals who think the case for rights should be neutral toward substantive moral and religious doctrines and communitarians who think that rights should rest on prevailing social values
possible for physicians to thoroughly understand and integrate their patients’ particular aims. Since medicine originates in the suffering of patients and culminates successfully only in the mitigation or amelioration of this suffering, it is the experience of patients that should guide the practice of medicine. To a large degree, the moral mission (and public standard) of medicine is to empower patients. On the other hand, the asymmetry of control that favors patients is limited. Physicians should be sensitive to patient vulnerabilities and attempt to remedy them where possible. But sometimes patients’ vulnerabilities are too immense to be overcome. Sometimes the medical alternatives are too intricate or complex to be readily explained. Sometimes the patient (or patient proxy) is just too tired, too sick, or too emotional for effective deliberation. In these situations, physicians must take the lead. Further, there are situations where patients’ (or patients’ proxies’) decisions are clearly at variance with the moral standards of the GMC. Here, the physician is expected to oppose patient preferences. For instance, a patient who demands fluoroquinolone antibiotics for a moderate case of watery diarrhea should not be indulged. Though these medications are unlikely to hurt such patients and may even help (via the placebo effect or in the unlikely event that there is a treatable bacterial pathogen), using fluoroquinolones in these cases would seriously hamper the effort to improve the quality of clinical medicine (by promoting bacterial resistance).

Cases where patients demand medically futile treatments are frequently analogous. Certain objectives might be attained by the administration of these treatments. Hence the treatments are not futile with respect to these objectives. Nevertheless, the treatments are medically futile insofar as the objectives that might be achieved are not legitimate objectives of the GMC.

Conclusion

For both Helga Wanglie and Baby K, misgivings about the use of life support were based on the conviction that preservation of human life should be a clinical goal only where there is likelihood of preserving or restoring consciousness. Typically, this conviction has been based on professional consensus.24 Though I believe this view may be warranted, I do not believe professional consensus provides such a warrant. Public consensus would be more compelling, but is also insufficient.

For medicine to establish this view and convert it into policy, it must consult the concerned public, and in order to respond authoritatively, the concerned public must invoke the ideals of the GMC. This process will involve the articulation of a public philosophy that includes an account of the goods that make the prolongation of human life worthwhile. Perhaps this account will be broad and nonspecific (which is not to say that it would be “thin” in the Rawlsian sense). If so, the GMC might sanction mutual regard (stronger than mutual respect) for several possible interpretations of the value of preserving unconscious human life and require the medical profession to honor patient commitments to any of these interpretations. Or perhaps the GMC will hold that preservation of permanently unconscious human life countervalues important public values and should not be practiced. One support for this latter position might be the fact that preserving permanently unconscious human life is expensive. This consideration would be especially relevant in a universal coverage scenario, where healthcare was publicly financed. In such cases, the moral determination of appropriate goals is
Responses and Dialogue

affected by an assessment of the burdens inflicted by the pursuit of these goals. Thus our choice between rival interpretations of medical futility might be predicted on benefit–burden analysis, despite the fact that the concept of futility, in itself, contains no such analysis.

Another characteristic of arguments that limit goals on the basis of extrinsic burdens such as cost is that they are historically contingent and therefore open to revision. If we conclude that life support for anencephalic patients or those in a permanent vegetative state is illegitimate because it is expensive and intrusive (for those who provide it), then we are required to revise our position when and if inexpensive and noninvasive forms of life support are developed. It follows that even a perfect account of the goals of medicine will be open to future revision. This observation falls in line with the dynamic, experimental account of moral values recommended by classical pragmatists such as Royce, Peirce, and Dewey. The GMC is an ideal community. But it should not be confused with a utopian standard. Instead, it is a historically contingent best approximation of flourishing humanity, predicated on historical, cultural, and scientific facts and engendered by our response to current problems.

With respect to the problems at hand, I do not believe that Mr. Wanglie or Baby K’s mother had sufficient warrant for establishing the prolongation of life as a legitimate medical goal for their wards. Thus I concur with Schneiderman that life support in these cases was medically futile. With Schneiderman, I must address the lack of consistent public support for withdrawing life support from the permanently unconscious. This lack of support is manifested by the prevalence of PVS patients on ventilators.

On the other hand (and more to the point of this essay), I depart from both Schneiderman and Brody by rejecting altogether the notion of unilateral decisions about withholding treatments based on a determination of medical futility. Clinical deliberation is a triadic process, always involving input from patients, clinicians, and the GMC. Most of the time, input from the GMC comes in the form of normative conventions embedded broadly in the American culture of illness. Sometimes, it comes through the mediation of explicit moral norms, policies, and standards of practice, invoked by medical decisionmakers. Less commonly, the GMC operates through the agency of hospital ethics committees, courts, and legislatures. Finally, the input of patients and their proxies is always relevant, even with respect to decisions about some treatments that are considered “physiologically futile” by physicians.

Of course, most physiologically futile treatments do not need to be discussed. When a patient seeks treatment for a sore throat, there is no need for deliberation about whether to use peritoneal dialysis. However, antibiotics are physiologically futile in viral pharyngitis, yet they should be discussed since they are often used in other forms of pharyngitis and patients are likely to wonder about them. In the terminology of William James, they are a “live option” for many patients, even if they are a bad option. Should patients have the privilege of unilaterally compelling doctors to prescribe antibiotics in these cases? Of course not. But antibiotics should not be unilaterally withheld either. Doctors should withhold antibiotics from insistent patients only after engaging these patients and invoking the authority of the GMC (through an appeal to scientific standards of evidence).

In the end, futility is a simple concept that is difficult to interpret in clinical practice. It is difficult to interpret
Responses and Dialogue

because actual instances of medical futility are determinable only through reference to a theory (implicit or explicit, fragmentary or comprehensive) of the good. As for all morally compelling ideas, cogent interpretations of medical futility come only through a deliberative process that involves the broadest possible array of interested and committed parties. This process includes elements of consensus building, but consensus is neither necessary nor sufficient for community action. Consensus is unnecessary when urgent action is required and compromise is possible. It is insufficient when it does not reflect informed, democratic deliberation. Regarding interpretations of medical futility, there is currently no consensus and the process of deliberation, though under way, has not progressed to the degree where a durable compromise is possible.

Notes

3. In The Loyal Physician: Racoon Ethics and the Practice of Medicine (Nashville, Tennessee: Vanderbilt University Press, 1997), I use Brody’s conception of the “broken story” to discuss the importance of narrative in clinical medicine, endorsing his opinion that clinical medicine involves the physician in an effort “to develop over time into a certain sort of person—a healing sort of person—for whom the primary focus of attention is outward, toward the experience and suffering of the patient, and not inward, toward the physician’s own preconceived agenda” (emphasis in original). However, Brody’s account of the physician’s personal transformation into a person dedicated to helping patients reestablish a satisfying life narrative does not sit well with his contractarianism. For instance, Brody criticizes “covenant” models of physician obligation because they imply broad personal commitments on the part of physicians. He writes: “it is crucial not to extend the scope of the physician–patient relationship beyond legitimate bounds,” then goes on to criticize Charles Fried for stating that physicians are servants of patients’ life plans. (Brody H. The physician-patient contract: legal and ethical aspects. *Journal of Legal Medicine* 1976;A:25–9.) For the material cited in The Loyal Physician, see Brody H. My story is broken; can you help me fix it? *Literature and Medicine* 1994;13:79–92.
6. Interestingly, when proponents of Schneiderman’s version of quantitative futility assessed medical residents’ use of the concept of futility, they found the residents diverged from Schneiderman. Instead of concluding that Schneiderman’s account needs revision, they concluded that the residents were in error. Curtis JR, Park DR, Krone MR, Perlman RA. Use of the medical futility rationale in do-not-attempt-resuscitation orders. *JAMA* 1995;273:124–8.
10. Since publication of The Loyal Physician, I have adopted a terminological distinction between the “concerned public” and the “greater medical community.” The former term designates the community of individuals who aim at establishing an ethical medical community. The latter term designates the ideal ethical medical community (the best possible medical community given current historical limitations). Members of the concerned public strive to achieve the GMC in the sense that they are devoted to building a truly ethical medical community, but not necessarily in the sense that they have a clear vision of the particulars of such a community. We say that members of the concerned public are members of the GMC.
because the GMC is a community of memory that includes all who have worked to bring it about.


15. In *Democracy’s Discontent: America in Search of a Public Philosophy* (Cambridge, Massachusetts: Harvard University Press, 1996), Michael J. Sandel argues at length that a sound public philosophy depends on social commitments to a conception of the good. This work builds on his earlier thesis that theories, such as Rawls’, that epistemologically prioritize the right over the good are unworkable. See also, Sandel MJ. *Liberalism and the Limits of Justice*, 2nd ed. Cambridge: Cambridge University Press, 1998.


26. Despite occasional claims that it depends on purely medical values (or that it is value neutral), the concept of physiologic futility hinges on general moral values in two important ways. First, the selection of physiologic end points for a treatment requires valuation. For instance, should the physiologic purpose of CPR be maintenance of organ perfusion during cardiopulmonary arrest, return of spontaneous circulation, return of cerebral function, or survival to discharge? (See Mahmoud RA. Letter to the editor. *Annals of Internal Medicine* 1996;124:76.) Second, even if the physiologic end points are given, the selection of a suitable criterion for “virtual certainty” that these end points cannot be achieved with a given intervention is a moral question.


28. Interestingly, patients who expect to receive antibiotics for viral infections are usually quite satisfied when antibiotics are withheld—just as long as physicians take the time to thoroughly explain the rationale for non-treatment. See Hamm RM, Hicks RJ, Bemben DA. Antibiotics and respiratory infections: are patients more satisfied when expectations are met? *Journal of Family Practice* 1996; 43:56–62.