

From the Editors

This issue of *CQ* begins with presentations by two renowned British philosophers, Baroness Mary Warnock and Mary Midgley, delivered at the "Bioethics in a Changing World" conference at Girton College, Cambridge University in August 1992, made possible by support from the Skaggs Foundation of Oakland, California. Baroness Warnock underlines the difficulty of looking to past centuries with regard to the moral problems raised by our new biological knowledge today. Questions such as "Ought we to do everything we can do, in the way of therapy or enhancement of human life?" and "If not, and some restrictions are to be imposed, what is the justification for these restrictions?" are inevitably, according to Warnock, as much political as moral issues. Mary Midgley looks at the often violently controversial characteristic of bioethics problems with their "traditions of gladiatorial debating" and asks if we must necessarily be forced to choose between our various ideals; for example, between justice and mercy. When good causes compete, must it always be a zero-sum game?

With the voices of Warnock and Midgley as background, we turn to an important shift in current bioethics debate. The right of patients to refuse treatment has given way to the converse—the right of patients or their surrogates to demand treatment. The keyword in the debate has become "futility." This issue's Special Section is devoted to the

demands, duties, and dilemmas inherent in futility determinations.

A problem in the past has been to frame the issue as if there were some technical definition of futility that, once determined, would clarify concerns and put an end to all debate. As theoretical discussions proliferate, scholars become suspicious that perhaps there is something "futile" about the notion of futility. The problem does not lie in being able to come up with a medical characterization of futility—that is already being done in a variety of ways and settings. A technical definition is not enough. Medical futility does not merely describe a medical problem but also a social one that is vastly complicated, not only because of the goals and values of the family but also because of the perceptions of society.

Ultimately, terminology is not sufficient for dealing with the patient who is characterized as suffering from something, the treatment of which would be medically futile. Patients in a persistent vegetative state (PVS) are illustrative of the fact that what complicates the futility issue is again not the particular diagnosis or prognosis of the patient but is instead a matter of how we react or respond to that patient.

The Special Section is introduced by two thought pieces by John Paris and Amnon Goldworth that argue that the ineffectiveness of the debates over limitations on providing requested treatment is due to a sterile preoccupa-

tion with word meaning or confusions over concepts. Paris proposes that a great deal of the emphasis has been misplaced. His corrective to that would be to bring us back to the central issue, which is not "What is futility?" but "What should be done?" Goldworth compares a patient in a persistent vegetative state to Jeremy Bentham and argues that our thinking is often muddled into believing a "person" is involved, when actually in PVS cases there is only something "person-like." If we are persuaded by Goldworth's account, then perhaps we make a wrong move when we view the on-goingness of PVS patients as "treatment." A more accurate term might be "enshrinement," thus taking it out of the realm of a medical category altogether. This does not mean, however, that the practice should be taken as a minor matter. We might decide as a society after long and careful discussion that PVS patients should be sustained, not because they will benefit but because it does us, the living, some good. In practicing what Goldworth calls a form of "idolatry," we may still avoid possible psychological injury to ourselves for not doing so.

The piece by William Knaus on risk stratification also acknowledges the benefits of the ritual components of medicine but cautions that as the costs of using the intensive care experience as a ritual towards death continue to escalate, we must become clear in distinguishing between what is "ritual" and what is "medical treatment." In determining the proper course of medical treatment Knaus's view is that "good ethics start with good facts," the impetus for the Acute Physiology, Age and Chronic Health Evaluation (APACHE) project. However, the way those facts are to be used in the light of patient preferences and values is open to controversy. In a paper sure to be the source of much debate to come, Nancy S. Jecker and Lawrence J. Schneiderman extend their previous work on medical futility to claim physicians are generally ethically obligated to refrain from using futile treatments.

The views presented here are meant to further discussions on the issue of futility, and we welcome your comments and critiques. Representative responses from readers will appear in future issues of *CQ*.