Futility
The Limits of Mediation

To the Editor:

In a recent issue of CHEST (December 2007), Burns and Truog1 argued that the history of futility can be divided into the following three sequential periods: the definitional approach; the procedural approach; and the conflict resolution approach. We agree that attempts to define futility have failed, and we agree that the procedural approach of the Texas Advance Directives Act fails to accord necessary due-process protections. But the last two stages in the schema devised by Burns and Truog should be reversed. Recognition of the limits of mediation at the end of life has given rise to procedurally based legislative initiatives, not the other way around.

Although Burns and Truog acknowledge that “even impeccable efforts at negotiation may sometimes fail,” they nonetheless point to mediation as the last, best hope of the medical community in dealing with the most difficult of surrogate requests for nonbeneficial treatment. Their romantic embrace of mediation is, perhaps, unsurprising. Mediation has been touted in many quarters as the magic band-aid that is ideally constituted to solve the most confounding conflicts of bioethics. But, if by mediation we mean a process in which both sides work to find a creative solution that differs in some way from their initial starting points, then that is not happening in a significant and expanding subset of cases. Rather, in this subset of intractable futility cases, disputant bargaining invariably leads to a predictable outcome. Providers accede to the surrogates’ adversarial positioning, and the patient receives the demanded treatment.

We must stop asking mediation to do more work than it is structurally equipped to handle. In most jurisdictions (other than Texas), the mediation of futility disputes occurs in the shadow of decisions in health-care law that give vastly more bargaining power to surrogates. Normative uncertainty in the judicial realm buoys surrogates who are propelled by strong emotion and fierce moral conviction. The same uncertainty fuels providers’ risk aversion, leading them to back down in the face of strongly worded surrogate demands.

Whether meant as historically descriptive or normatively prescriptive, the evolution of futility devised by Burns and Truog inverts the order of the process. Mediate and accede is the status quo. Procedural approaches work to buttress clinical authority by strengthening providers’ best alternative to negotiated agreement (or BATNA) and supplying needed bargaining chips. If we want “real” mediation, then we must equalize the bargaining power between providers and surrogates by giving providers a clearly defined statutory safe harbor to unilaterally refuse requests for inappropriate treatment.

Thaddeus Mason Pope, JD, PhD
Widener University
Wilmington, DE

Ellen Waldman, JD, LLM
Thomas Jefferson School of Law
San Diego, CA

The authors have reported to the ACCP that no significant conflicts of interest exist with any companies/organizations whose products or services may be discussed in this article. Reproduction of this article is prohibited without written permission from the American College of Chest Physicians (www.chestjournal.org/misc/reprints.shtml).

Correspondence to: Thaddeus Mason Pope, JD, PhD, Widener University, Law, 4601 Concord Pike, Wilmington, DE 19803; e-mail: tm pope@widener.edu

DOI: 10.1378/chest.08-0589

References
2 Pope TM, Waldman EA. Mediation at the end of life; getting beyond the limits of the talking cure. Ohio St J Disp Resol 2007; 23:143–194

Response

To the Editor:

We thank Pope and Waldman for their thoughtful response to our recent article in CHEST (December 2007) and acknowledge that they made several excellent observations about the limits of mediation as a general strategy for resolving disputes. As applied to the problem of medical futility, however, the validity of their critique hinges entirely on the penultimate word of their letter, “inappropriate.” They claim that providers need “a clearly defined statutory safe harbor to unilaterally refuse requests for inappropriate treatments,” thereby implying that the word “inappropriate” has a commonly understood meaning or agreed-on definition. The truth is that no such meaning or definition exists.

Consider, for example, that while some requests for life-sustaining treatments are certainly the results of denial, delusion, or magical thinking, others emerge from genuine commitments to fundamental values. For example, some people believe that judgments about “quality of life” from neurologic disability should not be a factor in making decisions about the withdrawal of life support. While this belief is not popular, it is not irrational. Our country is (or at least should be) committed to protecting the rights of people to hold and to act on minority viewpoints. While we do not guarantee that these views will always prevail, they certainly deserve legal protection.

The Texas law, as we understand it, circumvents these protections in at least two ways. First, it grants hospital ethics committees the sole authority to determine the meaning and definition of the word “inappropriate.” While acknowledging that these committees are composed of thoughtful, compassionate, and well-meaning individuals, the members are typically physicians, nurses, social workers, and other employees of the hospital, many of whom have unavoidable financial and psychological connections to the hospital, creating untenable conflicts of interest. Even the so-called community members of the ethics committee are often individuals who have chosen to serve because of the