

# No Heroic Measures: How Soon Is Too Soon to Stop?

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## Introduction

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As cardiothoracic surgeons, we face many difficult problems in our professional lives, and base most decisions on clinical judgment developed and honed during many years of training and experience. Some decisions, however, are based on more than weighing scientific evidence and outcome probabilities, and they require value judgments on such matters as the desirability of alternative outcomes. Among the most difficult judgments we make are those that conflict with the views of the patient or the patient's proxy (ie, agent appointed in advance by the patient) or surrogate (ie, agent authorized by law) decision maker.

In cases of critical illness with low survival probability, discordant judgments about withdrawing life support are often based on perceived acceptability of the projected quantity and quality of life if the patient survives. The surgeon and the proxy or surrogate might find themselves on either of the opposing sides of the issue.

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In such decisions, much hinges on what the patient would have wanted. In both law and ethics, proxy or surrogate decisions generally should be based on substituted judgment, that is, a judgment that answers the question: "What would the patient have wanted?" The most wrenching of such conflicts occurs when the surgeon wants to continue treatment and the proxy or surrogate wants to stop, presumably because the patient would have chosen to stop. In the absence of a written advance directive that clearly specifies what the patient wants done in a life-threatening situation, acceptability of the decision of a proxy or surrogate turns on the weight of evidence that the decision of the surrogate or proxy accurately reflects the patient's wishes. The case

below illustrates just such a difficult surgeon-family conflict and it is the focus of the debate that follows.

### The Case of the Resolute Wife

John Cooper is a 40-year-old restaurant owner, who has a wife and two children, 20 and 22 years old. He is a 45-pack/year smoker and complains of chest pain, located in the right chest wall. A chest roentgenogram shows a mass in the right upper lung field. Diagnostic workup discloses squamous cell carcinoma of the lung, stage IIB (T3N0M0), invading the chest wall. His surgeon, Dr William Ashley, performs a difficult right upper lobectomy with chest wall resection. The pathology report confirms the histology and stage of the cancer; the margins of the surgical specimen have no residual tumor and the lymph nodes contain no malignant cells.

The patient does well initially, but on postoperative day (POD) 2, respiratory distress and a fever of 40.5°C develop, and a chest roentgenogram shows pneumonia. Increasing distress requires reintubation and transfer back to the cardiothoracic intensive care unit. On POD 4, the chest roentgenogram shows early signs of a bilateral fluffy infiltrate, with the oxygen requirement and peak airway pressure are increasing, and no evidence of heart failure. By POD 6, it is clear that the patient has adult respiratory distress syndrome. Dr Ashley has excellent rapport with the family, which seems to be cohesive and is devoted to their husband and father, respectively. The surgeon informs the family of the patient's steadily worsening prognosis.

By POD 8, the lung problem is worse and signs of renal failure have appeared. Dr Ashley spends considerable time with the patient's wife explaining her husband's clinical condition, including the likelihood that he will soon require hemodialysis. For the first time, she mentions that she and her husband have talked about the use of "heroic measures" if one of them should develop a serious or terminal illness from which full recovery was unlikely, and he did not want such measures. The patient's wife determines that dialysis should not be used.

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Dr Ashley explains that the patient's chance of recovery is not high, but is not zero, and dialysis might successfully manage his renal failure, allowing his lungs time to recover. The patient's wife is unconvinced. The surgeon suggests that they wait over the weekend, and see what happens, as the decision can be delayed for a few days. The patient's wife agrees; she is also willing to talk with the hospital ethics committee. Committee members meet with her several times over the weekend.

On POD 11, the need for dialysis is imminent; the potassium level now is 5.9 mg/dL and rising. Managing the adult respiratory distress syndrome is still difficult, but it has not become worse over the weekend, and no cardiotoxic drugs have been required. Dr Ashley discusses the situation again with the patient's wife, also with the ethics committee representatives present. The surgeon again expresses his belief that it is in the patient's best interest not to withhold dialysis. He has a reasonable chance of surviving his pulmonary and renal

problems (with the surgeon's guess of perhaps a 20% probability of leaving the hospital alive with a good quality of life) and a fairly good chance of surviving his cancer (published data suggest a 50% chance of being alive in 5 years). Moreover, in this day and age, dialysis and artificial ventilation can not be considered heroic treatment. The ethics committee scrupulously carries out its role as educator and mediator. In the end, the patient's wife still insists on withholding dialysis.

Dr Ashley now sees two options. He can follow the decision of the patient's wife and allow his patient, with a potentially treatable organ failure, to die soon from progressive renal failure. Alternatively, the other option based on the grounds of doing what is in the patient's best interest, he can ask the hospital attorney to seek a court order to continue treatment. He wants to do the right thing for his patient, but he is not sure which course is best. He decides to ask two of his colleagues for their thoughts.

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## Pro

Thomas A. D'Amico, MD

The pro stance would be for Dr Ashley to honor the decision of the patient's wife to not provide dialysis. The need for physicians, patients, and families to confront the issues of withdrawal of support and medical futility, as highlighted in this hypothetical case, is important and unfortunately familiar to cardiac and thoracic surgeons. Decisions regarding the use, withdrawal, or withholding of life-sustaining care are usually not difficult to make. When there is uncertainty about prognosis and the rights of others to make decisions for the patient, medical, ethical, and potentially medical/legal controversies may be difficult to manage.

Although conflicts have arisen in several reported cases in which a patient was competent to make a decision about end-of-life care [1], conflicts regarding withdrawal of support more commonly occur when the patient lacks the capacity to express his or her wishes regarding a specific decision [2, 3]. One study demonstrated that physicians and families are responsible for the majority of the decisions about life support in intensive care units, because fewer than 5% of patients are able to communicate with clinicians at the time the decision is made [4]. Conflicts commonly arise when a physician recognizes medical futility and the family does not [2, 5, 6]. Less commonly, the family expresses the desire to withhold or withdraw support, against the physician's judgment, as in this case. In addition, this case is complicated by the lack of a living will or written advance directive, and the issue of a surrogate's right to decision making is an element of the conflict.

The intended peripheral role of law when end-of-life dilemmas arise is often forgotten in debates such as this [7]. The law prohibits active killing, and clear advance direc-

tives must be followed if they have been properly executed. But within these bounds, end-of-life questions are almost always resolved privately, by patients, their physicians, and their family members, working with nurses, social workers, and members of the clergy [6]. Within wide boundaries, we must honor the wishes clearly stated by the patients. This commitment not only safeguards the liberty and dignity of the patient, but it also protects against family strife when a patient's intentions are clear.

Regarding the primary question posed by this scenario of whether Dr Ashley should ask the hospital attorney to seek a court order to continue treatment, the only possible answer is no. First, based on precedents, it is unlikely to be successful. Second, there are other options. This summary, however, does not do justice to the difficult decision-making process entailed in this case and others like it. To fully address the complex issues that define this case, Dr Ashley must answer the following questions: What are the chances of the patient surviving this critical illness with a reasonable quality of life outside the hospital? What measures must be taken to accomplish his recovery? How much suffering will further care impose on the patient's wife and his family? What resources would be expended in that care? In the absence of a written advance directive, how can the patient's wishes best be expressed? If the patient's wife is not justified in being allowed to make this decision to withdraw support, what decisions would she be capable of making? I will address these questions sequentially.

*What are the chances of the patient surviving this critical illness with a reasonable quality of life outside the hospital?* Evaluation of prognosis requires assessing age, cancer

stage, severity of illness, presence of organ dysfunction, reversibility of ongoing processes, and chance of cognitive function beyond the intensive care unit.

At 40 years of age, the patient is relatively young, which improves his chance of recovery and also supports an aggressive strategy. Currently, his cancer is staged at T3N0 (stage IIB), with no evidence of metastases [8]. His chance of being cured is approximately 30% to 40% [9,10]. In addition, the optimal treatment of his lung cancer would include adjuvant therapy [11], for which he is no longer a candidate. As he battles postoperative pneumonia, sepsis, adult respiratory distress syndrome, high ventilatory support, and renal failure imminently requiring dialysis, the severity of illness is best described as high, and the possibility of complete recovery as relatively low. Thus, his chance of recovery and long-term survival would be estimated by multiplying the likelihood of survival from the acute process (40-year-old man with postoperative pneumonia, sepsis, adult respiratory distress syndrome, and renal failure after lobectomy and chest wall resection) by the cure rate for his lung cancer (30% to 40%). Although a precise analysis of prognosis is impossible and unnecessary to make a decision in this and most cases, a general understanding and thorough accounting of the prognostic variables is important [12].

*What measures must be taken to accomplish his recovery?*

Further efforts to achieve recovery would include acute and possibly chronic dialysis, tracheostomy, and prolonged ventilatory support, gastrostomy, and rehabilitation. Although mechanical ventilation and hemodialysis may not be considered heroic or extraordinary compared with extracorporeal membrane oxygenation or left ventricular assist device use, the definition of heroic or extreme measures must be considered from the patient's (or surrogate's) point of view. Although all of these measures are offered routinely in the intensive care unit, are they reasonable to apply to a man with a poor prognosis if he would be likely to decline if he was capable?

*How much suffering will further care impose on the patient and his family?* Although the suffering imposed on the patient difficult to assess, the suffering imposed on the patient's wife would likely be high. It certainly seems that she has given the decision to withhold dialysis careful consideration. She has involved her husband's surgeon and the hospital ethics committee for advice, and she has stated specifically that she and her husband had discussed this difficult decision, and that he would refuse further care. Thus, one would conclude that the imposition of further (unwanted) care would be traumatic and injurious to the family.

*What resources would be expended in that care?* Although a surgeon's primary responsibility is to optimize the outcome of the patient's care, it is irresponsible to ignore the issues of cost and resource utilization. In some cases of medical futility, where the chance of survival is less than 1%, the application of extraordinary care should be avoided, not because it wastes resources but because it represents ineffective medicine [4, 13]. In this case, resource expenditure could be

justified if consent for its use (ie, specifically dialysis) were to be obtained.

*In the absence of a written advance directive, how can the patient's wishes best be expressed?* All states have adopted policies on the use of advance directives, such as the living will. These documents are designed to outline a strategy for decision making at end-of-life care. In addition, patients may designate a healthcare power of attorney, to apply the decisions of the advance directive or address other decisions not previously anticipated.

Although these important documents may greatly facilitate ethical end-of-life decision-making, they do not obviate the need for the surgeon to address the issues of critical illness and the patient's wishes regarding decisions in the informed consent process. Although this issue is not specified in the hypothetical scenario, one can only assume that either the topic was not discussed or that the patient's wife is correctly representing her husband's wishes, because Dr Ashley does not dispute the point. Thus, in the absence of a written advance directive, decision-making for a patient at the end-of-life is made by the next of kin, or the patient's wife. She articulates that she and her husband have addressed this issue previously, and there is no reason to doubt her. Therefore, decisions regarding consent for further care are clearly hers to make.

*If the patient's wife is not justified in being allowed to make this decision to withdraw support, what decisions would she be capable of making?* In the current case, this rhetorical question highlights the established role of the patient's wife as the legal surrogate, as she has appropriately made decisions regarding care since the onset of the critical illness. Displacing her now, because she is making a decision to which Dr Ashley disagrees would call into question her authority to this point. Thus, if the patient's wife is capable and empowered to make decisions consenting to the care to the current stage of care, she is equally capable and empowered to make decisions declining care (assuming effective communication with Dr Ashley).

## Recommendations

In considering these questions, one can make the following recommendations for Dr Ashley:

1. Do not take the case to court, but consider other options.
2. Talk to the entire family about what the patient would want in this situation. Two adult sons might shed light on the situation and may be able to convince the patient's wife to consider a limited course of further treatment. Further discussion among the family about the perception of the definition and limits of "heroic" care may be convincing. Remember that family members often do not understand information regarding diagnosis, prognosis, or treatment [4], and physicians often miss important opportunities to allow patients and

family members to discuss their personal values and goals of therapy [14].

3. Delay urgent dialysis with other clinical alternatives to allow further dialogue. Hyperkalemia could be temporarily managed with calcium, glucose, and insulin. Although this treatment is not as effective as hemodialysis, the option of peritoneal dialysis could be discussed as well.
4. Propose a negotiated approach in regard to reaching specific clinical goals and using these goals in the decision-making in regard to continuing or withdrawing care. One option would be to set a goal for a specific time limit for dialysis, to allow recovery of the lungs and the kidneys.

It would not be wrong to proceed with dialysis if the family supported it. If further support is withheld, that decision could not be criticized if the family believes that it represents the patient's wishes. If the family refuses, it would be inappropriate to insist on dialysis based on what is known now about the patient's preferences and his chance of survival.

## Conclusion

Surgeons should strive to understand clearly the ethical and legal issues involved in end-of-life care, including the function of an advance directive, healthcare power of attorney, individual state medical futility acts, and American Medical Association policy on these issues [15]. Unfortunately, only 20% to 30% of adults are estimated to have advance directives, and in 35% of those, the directives can not be found when needed [4]. Utilize consults from ethics committees or palliative care services to improve end-of-life care. Address impending issues before a decision must be made urgently or emergently. Negotiate decisions based on clear, easily understandable goals and milestones. The overarching goal of courts, clinicians, and others with a say in end-of-life disputes should be to pursue private, family-based decisions within the wide limits set by law. Practice medicine in the hospital, not the courtroom; avoid the legacies of Karen Ann Quinlan, Nancy Cruzan, Terri Shiavo, and Emilio Gonzalez [2].

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## Con

Mark J. Krasna, MD, and Diane M. Krasna, CRNA

The con stance would be for Dr Ashley to seek a court order to provide dialysis for his patient. We strongly believe that unless treatment causes unneeded pain or suffering to no avail, it is incumbent on a physician to act in the patient's best interest to provide care and treatment with every resource available. We believe this is a moral and ethical obligation based on the principles of beneficence and nonmaleficence (ie, being of benefit to the patient and doing no harm). Hippocrates suggested three major goals of medicine: "cure, relief of suffering, and refusal to treat those who are overmastered by their diseases" [16]. Some might use these words to advocate stopping treatment, but we will explain the smokescreen that has been inappropriately promoted and continues to be advocated by those who argue for cessation of all curative treatment with very loose boundaries. We also hope to demonstrate how to distinguish between futile, "heroic" care and what is realistic, supportive care during an acute postoperative crisis. Good communication with patients and their families preoperatively and postoperatively is imperative. An operative consent covering postoperative situations and giving the surgeon the latitude necessary to act in the patient's best interest is needed. We must educate patients, their families, and collaborative healthcare workers to fully understand the difference between medically appropriate, supportive care, and end-of-life palliative care.

## Consent

Informed consent is a central legal and ethical concept for this discussion. Legally speaking, consent is explicit or implied. The patient entered into an explicit contract with Dr Ashley when he came to his office and consented to surgery. The patient expressed his desire for surgery, fully knowing its possible life-threatening complications and potential long postoperative course. Dr Ashley assured the patient of his commitment to steer him through all of that just previously mentioned as his surgeon, to the best of his ability, as per the operative permit and Dr Ashley's explanations before surgery.

The World Medical Association Declaration on the Rights of the Patient states: "The patient has the right to self-determination, to make free decisions regarding himself/herself. The physician will inform the patient of the consequences of his/her decisions. A mentally competent adult patient has the right to give or withhold consent to any diagnostic procedure or therapy. The patient has the right to the information necessary to make his/her decisions" [17]. Good communication between physician and patient is essential for truly informed consent. This involves explaining complex diagnoses, treatments, and prognoses in simple language, ensuring the patient's grasp of the information, answering questions, and explaining advantages and disadvantages of the options.

The community, the state, and third party payers have all acknowledged the physician's responsibility to iden-

tify medical necessity; the expertise and judgment involved in clinical decisions are essential aspects of professionalism. But the extent of that professional role is being increasingly challenged. The physician-patient relationship has changed. Bioethical models advocate increased patient autonomy in decision making, and the physician's opinion and recommendations about what is in the patient's best interest have become increasingly subject to patient review. No major dilemma occurs when patients, families, and the physician agree on goals and the desired treatment to achieve these goals [17]. The dilemma exists when the physician has not had the opportunity to advise a competent patient in the presence of his family and later has to deal with a surrogate who does not have the full picture, or is incapable of dealing with the situation, or does not want the burden of care, or a combination of these.

### Advance Directives

While we are told that the patient gave an oral advance directive, we do not believe that it "holds water" postoperatively. In the present scenario, the patient and surgeon have entered into a contract with the understanding that for the duration of surgery and the postoperative period, any prior directives are null and void, and postoperative care that might be considered "heroic" are now standard, lifesaving measures. A clear distinction *must* be made between patients facing unexpected, futile, long-term care and the current scenario; what is being proposed by Dr Ashley in this case is appropriate, supportive care with a reasonably hopeful outcome. Professional responsibility of a physician to do no harm also implies the moral authority to judge the benefits of medical interventions [17]. Arrogance aside, who knows better than the physician, from his experience with similar cases and scenarios as to what can work and what should be tried.

We are told that the proposed treatment plan for dialysis has been explained to the patient's wife and she had refused on the grounds that she and her husband had "talked" about the use of "heroic measures" if one of them should develop a terminal illness from which recovery was unlikely. Dr Ashley repeatedly expresses his feelings that it is in the patient's best interest for the wife *not* to withhold dialysis; today, dialysis and mechanical ventilation can not be considered "heroic treatment."

### Ethics Committee

The ethics committee educates and mediates, but in the end the patient's wife still insists on withholding dialysis. Dr Ashley is left with two options: (1) allow the patient's wife to decide to let his patient with potentially treatable organ failure to die unnecessarily soon from progressive renal failure, or (2) on the grounds of doing what is in the patient's best interest and what the doctor has been contractually engaged to do, he must ask the hospital attorney to seek a court order to continue treatment.

Here we will emphasize Dr Ashley's obligation both morally and ethically to act on his patient's best interests. We will look at the implementation of the ethics committees, their limitations, and possible risks of coercion, unintended or intended, and the appropriateness or inappropriateness of empowering a body of perhaps less medically knowledgeable people to advocate for the patient.

It is incumbent on physicians operating on advanced lung cancer to have excellent communication skills. They must explain the difficulties anticipated and sometimes dreaded, and the steps that will be taken to correct postoperative complications and actually prepare an explicit, informed consent stipulating postoperative treatments that would or could be interpreted or misinterpreted as heroic, life saving, and possibly misconstrued as futile. Legally, consent may be given orally or in writing. Consent is implied when the patient indicates a willingness to undergo a procedure or treatment by his behavior. For treatments that entail risk or discomfort, it is preferable to obtain explicit written consent. Situations in which the patient voluntarily gives decision-making authority to a physician or third party are exceptions to the requirement for informed consent [17]. This is implied with postoperative complications, and the surgeon is expected to do what is in the patient's best interest. Does the informed consent supersede the advance directive? After thoracic procedures, the consent generally includes management of perioperative complications, such as bleeding that requires emergency surgery.

Advance directives, whether oral or written, for discontinuing curative treatment should be declared null and void for a specific period of time, defined by patient and surgeon, and the person acting as surrogate should be informed of this fact. (St. Joseph's Medical Center policy states that a no-code or do not resuscitate [DNR] order may be suspended during an operation and the early postoperative period unless the patient's expressed wish is otherwise, and the surgeon and anesthesiologist are willing to care for the patient under those conditions.)

### Education and Communication

The patient's wife has limited medical knowledge at best; the ethics committee in a perfect world would have profound understanding of the postoperative care available and be able to articulate and convince the patient's wife that the surgeon's recommendation is appropriate and in the patient's best interest. Too often, ethics committees are empowered to sign off on care or assume that they need to consider allocation of finite institutional resources and miss the conflict that the patient is being used as a means to the family's or hospital's ends.

A discussion on withholding and withdrawing life-sustaining therapy and the surrogate's role and commitment to supporting the patient's rights and best interests is detailed in the official statement of The American Thoracic Society adopted by their board of directors in March 1991. It supports the decision "to continue life-sustaining treatment when the patient no longer has decision-making capacity, based on the knowledge of the

patient's preferences, values, and goals, and their commitment to supporting the patient's rights and best interests" [19]. The surrogate should make the same decisions about the patient's care as the patient would have made if capable of doing so, concerning the use of life-sustaining therapy: "If the patient made no known prior oral or written statements, or if they are not applicable to a particular decision, then the surrogate should use his/her best judgment of what the patient would have preferred under circumstances based on his/her understanding of the patient's values and goals in life." It goes on to detail circumstances when a surrogate can't make a decision, and it outlines a reasonable process for a patient's physician and other healthcare providers to make decisions for the patient based on what is determined to be "in the patient's best interest." This process should be as reasonable and objective as possible, weighing the benefits for starting or continuing a certain life-sustaining therapy against its burdens on the patient. If the benefits of the therapy exceed the burden, the therapy should be administered.

This statement brings out difficulties with the surrogate, from examples of potential influence of personal gain from a certain decision, and further examples of not knowing the patient's preferences or goals, which should determine decisions made on a patient's behalf. This emphasizes the need for specifics of the patient's preferences in advance directives and the need for detailed surgical consent that includes postoperative contingencies and putting the advance directive on hold. Persistent disagreement by surrogate and physician may have to be addressed by the ethics committee and as a last resort by judicial review.

### Futile Care

The word "futile" is derived from Latin roots meaning, "that which easily pours out, is ineffective, or useless." It is also defined as frivolous or lacking serious purpose, and implies a decision about outcome probability that we do not have, ignoring the wide range of treatments for a given diagnosis [20]. The ethical principles of beneficence and nonmaleficence underlie and define treatment goals, so the purpose of a life-sustaining intervention should be restoration or maintenance of a patient's well being, not mere prolongation of biological life. On this basis, a life-sustaining intervention may be withheld or with-

drawn from a patient without the consent of the patient or surrogate if the intervention is judged by the physician to be futile. A life-sustaining intervention is considered futile if reasoning and experience indicate that the intervention would be highly unlikely to result in meaningful survival for that patient [18]. Here, meaningful survival specifically refers to a quality and duration of survival that would have value to that patient as an individual. How do we define heroic care? Is doing an operation with mortality greater than 3% heroic? Is temporary ventilator support heroic? Does hemodialysis mean no long-term survival? How about enteral feeding in a patient undergoing esophagectomy after chemoradiation with a 10% projected mortality?

Predictive models such as the APACHE III systems are useful in large populations, but they are not intended to predict an individual's risk of death. There are no precise measurements to predict an individual's outcome with comparable precision. Physician experience and intuition often serve the patient's best interest [21].

### Conclusion

If the patient's wife cannot be convinced by a step-by-step plan for appropriate life-supporting measures intended to improve the patient's outcome, it is incumbent on Dr Ashley to seek a court order to continue treatment. This would not have been necessary if the doctor had adopted our current practice in which we discuss suspending specific aspects of any existing advance directive for a defined period of time during the preoperative informed consent conversation with the patient and those closest to him. Then we record the joint decision in the medical record.

The patient and physician and the physician and family relationships are most likely to be optimal with excellent communication from the outset with compassionate conversations, acknowledgment of an advance directive, agreement to suspend it for a specified time, and education about the meaning of specific scenarios in the context of postoperative complications and their management. Involving an intensivist and a thoracic surgeon to serve on ethics committees would go far, when they are called on to advise and negotiate with a surrogate. Working well together would hopefully eliminate the need for judicial involvement to achieve what everyone's goal should be (ie, serving the patient's best interest).

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## Concluding Remarks

Robert M. Sade, MD

**D'**Amico and Krasna and Krasna provide an illuminating discussion, presenting discordant perspectives on this difficult problem. Two issues lie at the core of the quandary facing Dr Ashley: (1) the distinction between the substituted judgment and best inter-

est standards when making decisions for incapacitated patients, and (2) the extent of decision-making authority of proxies (ie, agents appointed by the patient) and surrogates (ie, agents designated by law or the judicial system).

## The Standard for Surrogate Decision Making

Most state law and most commentators on medical ethics prioritize substituted judgment over best interest. This priority of the substituted judgment standard is plainly stated in Maryland law (where Dr Krasna practices):

Any person authorized to make health care decisions for another under this section shall base those decisions on the wishes of the patient, and if the wishes of the patient are unknown or unclear, on the patient's best interest [22].

The ethical distinction between substituted judgment and best interest is clearly described and the priority of substituted judgment is supported by the American Medical Association's Code of Medical Ethics:

When there is evidence of the patient's preferences and values, decisions concerning the patient's care should be made by substituted judgment. This entails considering the patient's advance directive (if any), the patient's views about life and how it should be lived, how the patient has constructed his or her identity or life story, and the patient's attitudes towards sickness, suffering, and certain medical procedures. *If there is no reasonable basis on which to interpret how a patient would have decided* [emphasis added], the decision should be based on the best interests of the patient, or the outcome that would best promote the patient's well-being [23].

Both discussants fail to identify this distinction. D'Amico does not mention the best interest standard at all, even though circumstances in this case arguably might justify application of this standard. Krasna and Krasna state or imply that the surgeon's primary concern must be the patient's best interest (in a narrowly construed medical sense), but that position is contrary to both law and widely accepted medical ethics.

## Proxy or Surrogate Authority to Make Decisions

The authority vested in proxies and surrogates, according to both ethics and law, to make decisions on behalf of patients is stated clearly in the American Medical Association Code: "Physicians should recognize the proxy or surrogate as an extension of the patient, entitled to the same respect as the competent patient" [23]. Those who would override a surrogate's decision should ask themselves whether they would come to the same conclusion if the patient had made the same decision. The exception to this, of course, is the possibility of a compromised surrogate (ie, one who is acting in his or her own interest rather than in the patient's interest, or who is not competent for some other reason).

In both ethics and law, surrogate decision makers have essentially the same authority as the patient would have, if capable. Therefore, the central dilemma in this case is not whether the family believes that withholding dialysis represents the patient's wishes, as D'Amico believes, nor whether providing dialysis is in the patient's best interest, as Krasna and Krasna assert. The critical question is the validity of the patient's wife's decision and belief that her husband's oral directive included the withholding of dialysis (ie, whether her decision truly reflects the choice

that her husband would have made if he were capable of making this decision). No evidence suggests that the patient's wife has ulterior motives in her decision-making or that she is primarily serving her own interests rather than those of her husband; she is, for all intents and purposes, a competent, trustworthy surrogate decision maker.

In the end, we find that we can not tell Dr Ashley what the right thing is for him to do, because he failed to give his colleagues, Drs D'Amico and Krasna, a critical piece of information. The patient's wife judges that her husband would have considered dialysis "heroic" and would not want to continue treatment. To resolve the question of the right thing to do, Dr Ashley must first put aside his personal beliefs about the meaning of "heroic," about what course is medically indicated, and about the desirability of the quantity and quality of life in case of survival. Then he must decide, after weighing all the information at his disposal, whether the patient's wife has correctly judged that her husband would have refused dialysis. If the preponderance of evidence indicates that her judgment is accurate, the surgeon is ethically bound to honor her substituted judgment and withhold dialysis. If the evidence indicates that her judgment is mistaken, he is justified in seeking a court order to continue treatment and initiate dialysis.

At the end of the road, when all avenues for agreement have been explored and disagreement persists, the decisive factor is what the patient chooses. When the patient is incapable of choosing at the time of decision, the proxy or surrogate's choice is decisive *if* it accurately reflects what the patient would have wanted. Fortunately, we do not often have to disentangle the skein that lies beneath that "if."

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