

Medical Futility

As Christian physicians and dentists, we recognize the limitations of our art and science. We realize that not all medical interventions will offer a reasonable expectation of recovery or achieve the therapeutic goals agreed upon by the physician and the patient or the patient's surrogate. We believe that it is our duty to acknowledge the limits of medicine to our patients and their families.

We believe that clinicians should present the range of therapeutic options to their patients and recommend against therapy that does not offer a realistic expectation of benefit. To do otherwise engenders false hope in our human abilities and represents poor stewardship of medical resources.

However, the term medical futility should not be used when the real issue is one of cost, convenience, or distribution of medical resources. The determination of medical futility should not be made without the Christian physician realizing the heavy responsibility of no longer being able to prolong the life that God has created.

Because the physician-patient relationship is at heart a covenant, clinicians should work with their patients to reach treatment decisions that are mutually acceptable. They should not terminate treatment unilaterally on the basis of medical futility. However, they are not obligated to provide treatment that is contrary to their clinical judgment or moral beliefs. If a conflict cannot be resolved by further discussion or consultation, transfer of care is appropriate.

When transfer of care is not possible and the requested treatment is outside accepted medical practice, the clinician may be justified in withholding or withdrawing the treatment. In all situations, the clinician should serve as a healing presence of love, care and compassion. Our personal commitment to patients and their families is never futile.

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Explanation

Background

The concept of futility has been used for a long time in the practice of medicine, but only recently has it taken on major importance and at the same time generated major differences of opinion. On the surface, it seems like it should be a clear concept. A treatment is futile when it cannot provide benefit. However, the problem with the concept of medical futility is that it entails a value judgment about what is a benefit, and people differ in what they value as a benefit.

Prior to the 1960's, physicians were quite paternalistic; they made decisions about what should be done to their patients without their patients consent. Physicians held the power to write both prescriptions and hospital orders and the authority to make decisions about their use. In the 1960's and 70's, societal interest in individual rights, minority rights, consumer rights, etc. led to a professional emphasis on patients rights. [see Explanation of statement on Patient Refusal of Therapy] While physicians retained the power to prescribe, patients gained the authority to participate in medical decisions and to consent or refuse treatments recommended by their physicians. This major change in decision-making authority came gradually, encouraged by many court decisions that declared patients had a right to refuse treatments that they felt were too burdensome or risky, even life-prolonging treatments.

Some individuals have claimed that the redistribution of power from physicians to patients with regard to medical decision making gives patients not only the negative right to refuse physicians' recommendations but also the positive right to expect treatments even if physicians do not feel they are appropriate. Thus, some patients or their families have demanded the initiation or the continuation of specific treatments that physicians believe are not beneficial. Some physicians responded by saying, "The treatment you are requesting is futile" , relying on the truism that "there is no moral obligation to provide futile treatment." In two cases--those of Baby K, a child born with anencephaly, and Helga Wanglie, an 85 year-old woman in a persistent vegetative state--hospitals took families to court seeking permission from a judge to withdraw over the families' objection life support they considered futile. In both cases, the judges ruled in favor of the families, and the hospitals and physicians were directed by court order to continue treatments they deemed futile. The controversy over medical futility is thus another manifestation of the paternalism/respect-for-patient-autonomy struggle within the practice of medicine.

The concept of futility in medical practice is complicated even further when the fact of a placebo effect is considered. Often the presence of a treatment, any treatment, may seem to have a benefit for the patient. In calling a treatment futile, the clinician must take care not to remove the element of hope which may be engendered by the application of any treatment. At the same time, he or she must not encourage hope when there is no reasonable expectation of any physiological benefit.

Definitions

While everyone knows what the word 'futility' means, there is not agreement on what it means in the practice of medicine, or when it should be invoked. The word means "completely ineffective" . However, its application is complex because this definition includes both qualitative and quantitative components. It is a combination of low (as in zero) probability and low (as in none) benefit. But the practice of medicine and dentistry are imprecise. And futility is often invoked by clinicians when there is actually a very small percentage chance that the proposed treatment could work, or the possibility that it might achieve a small effect which the clinician believes is not worth the burden, risk, cost, or effort. So the professional often claims futility when he or she does not want to provide, for various reasons, the treatment under consideration.

Debate continues in the medical literature about such matters as (1) the definition of futility, (2) what clinical situations exist where there is a professional consensus that further treatment is futile, (3) whether physicians are obligated to even discuss treatment options which they consider to be futile, and (4) the process of dealing with a patient or family that is requesting treatment which is deemed futile by the responsible physician.

Futility should be clearly separated from rationing. Futility is the withholding of non- beneficial treatment, whereas rationing is the withholding of potentially beneficial treatment because it is not worth the cost. This distinction seems clear on paper, but may become blurred in the clinical setting where some individuals may make rationing decisions by claiming that the treatment is futile.

Christian Perspective

Christian physicians and dentists recognize that they are stewards of health knowledge and resources. All healing comes from God. He allows us to use our intellect and our abilities to facilitate healing in many clinical situations. Still, there are many situations when all the clinical skills and resources available will not change the course of events. In those situations, we are still called to minister to our patients.

CMDS addressed the issue of medical futility by reaffirming the covenantal nature of the patient-physician relationship, and encouraging shared decision-making. Part of the clinician's responsibility is to use clinical judgment in making recommendations, and occasionally to try to dissuade a patient from a course of action which will not be in his or her best interests because it would cause unnecessary suffering without reasonable expectation of benefit.

The statement on Medical Futility offers guidance on resolution of conflict about treatment decisions, and defines a very narrow window through which the clinician may unilaterally withhold or withdraw treatment deemed to be futile. In all situations, however, Christian physicians are reminded of the importance and worth of their commitment to their patients.

Abstracts

Wyatt J. Non-Treatment Decisions in the Care of the Newborn Infant. *Ethics & Medicine* 1998;14(2):45-49.

Technological advances have not only allowed us to live longer, it have given us the ability to save in increasing numbers those born too early. However, the author asks if it appropriate to provide intensive neonatal care for all low birth-weight babies? He discusses two differing philosophical views regarding the worth of a newborn infant and proposes two indications for the withdrawal of treatment, "First, the treatment is futile. Secondly, the patient is actively dying." He advises, "I want to emphasize the fact that withdrawal of intensive support is not the same as withdrawal of care. There is a minimum level of care with all newborns deserve....In fact, I regard providing terminal care to a newborn infant as really not different in kind from providing terminal care to a dying elderly patient."

Weijer C, Singer PA, Dickens BM, Workman S. Bioethics for Clinicians: 16. Dealing With Demands for Inappropriate Treatment. *Canadian Medical Association Journal* 1998;159(7):817-21.

"Demands by patients or their families for treatment thought to be inappropriate by health care providers constitute an important set of moral problems in clinical practice. A variety of approaches to such cases have been described in the literature, including medical futility, standard of care and negotiation. Medical futility fails because it confounds morally distinct cases: demand for an ineffective treatment and demand for an effective treatment that supports a controversial end (e.g., permanent unconsciousness). Medical futility is not necessary in the first case and is harmful in the second. Ineffective treatment falls outside the standard of care, and thus health care workers have no obligation to provide it. Demands for treatment that supports controversial ends are difficult cases best addressed through open communication, negotiation and the use of conflict-resolution techniques. Institutions should ensure that fair and unambiguous procedures for dealing with such cases are laid out in policy statements."

Helft PR., Siegler M, Lantos J. The Rise and Fall of the Futility Movement. New England Journal of Medicine 2000;343(4):293-96.

Much has happened since the concept of futility was first introduced in philosophical literature and currently the discussion is waning. In this article, the authors review the futility debate, from the first attempts to define futility to the fight between the autonomy of patients and doctors. They conclude, "the fall of the futility movement reminds us that using a descriptive concept as the foundation for a policy is highly problematic and does not relieve us of our obligation to talk to patients and their families and to explain why we think further treatment will have no benefit. The judgment that further treatment would be futile is not a conclusion – a signal that care should cease; instead, it should initiate the difficult task of discussing the situation with the patient. Thus, the most recent attempts to establish policy in this area have emphasized processes for discussing futility rather than the means of implementing decisions about futility. Talking to patients and their families should remain the focus of our efforts."

Lantos JD, Singer PA, Walker RM, et al. The illusion of futility in clinical practice. Am J Med 1989; 87:81-84

"The claim that a treatment is futile is often used to justify a shift in the physician's ethical obligations to patients. In clinical situations in which non-futile treatments are available, the physician has an obligation to discuss therapeutic alternatives with the patient. By contrast, a physician is under no obligation to offer, or even to discuss, futile therapies. This shift is supported by moral reasoning in ancient and modern ethics, by public policy, and by case law."

"Given this shift in ethical obligations, one might expect that physicians would have unambiguous criteria for determining when a therapy is futile. This is not the case. Rather than being a discrete and definable entity, futile therapy is merely the end of the spectrum of therapies with very low efficacy. Ambiguity in determining futility, arising from linguistic errors, from statistical misinterpretations, and from disagreements about the goals of therapy, undermines the force of futility claims."

"Decisions to withhold therapy that is deemed futile, like all treatment choices, must follow both clinical judgments about the chances of success of a therapy and an explicit consideration of the patient's goals for therapy. Futility claims rarely should be used to justify a radical shift in ethical obligations."

Schneiderman LJ, Jecker NS, Jonsen AR. Medical futility: its meaning and ethical implications. Ann Int Med 1990; 112(12):949-953

"The notion of medical futility has quantitative and qualitative roots that offer a practical approach to its definition and application. Applying these traditions to contemporary medical practice, we propose that when physicians conclude (either through personal experience, experiences shared with colleagues, or consideration of published empiric data) that in the last 100 cases a medical treatment has been useless, they should regard that treatment as futile. If a treatment merely preserves permanent unconsciousness or cannot end dependence on intensive medical care, the treatment should be considered futile ... Although exceptions and cautions should be borne in mind, we submit that physicians can judge a treatment to be futile and are entitled to withhold a procedure on this basis. In these cases, physicians should act in concert with other health care professionals, but need not obtain consent from patients or family members."

Truog RD, Brett AS, Frader J. The problem with futility. N Eng J Med 1992; 326:1560-1563

"The notion of futility generally fails to provide an ethically coherent ground for limiting life-sustaining treatment, except in circumstances in which narrowly defined physiologic futility can be plausibly invoked. Futility has been conceptualized as an objective entity independent of the patient's or surrogate's perspective, but differences in values and the variable probabilities of clinical outcomes undermine its basis. Furthermore, assertions of futility may camouflage judgments of comparative worth that are implicit

in debates about the allocation of resources. In short, the problem with futility is that its promise of objectivity can rarely be fulfilled. The rapid advance of the language of futility into the jargon of bioethics should be followed by an equally rapid retreat."

Veatch RM. Why physicians cannot determine if care is futile. JAGS 1994; 42:871-874

"I have become convinced that it is impossible for the bedside clinician to determine if medical care is futile. I mean this in both the empirical, scientific sense of not being able to make the determination and in the more normative sense of it being unethical to attempt to make such determinations."

Hook CC. Medical futility. Chapter 6 in Dignity and Dying. Grand Rapids, MI: Eerdmans, 1996:84-95

Written by a CMDS Ethics Commission member, this chapter gives a good overview of the history and content of the "futility debate". It also gives specific procedural guidance to assist clinicians as they confront patients or families who request interventions which the physician does not feel are appropriate. The conclusion is "In all situations, caregivers should serve as a healing presence of love, care, and compassion. Our personal commitment to patients and their families is never futile."

Halevy A, Brody BA. A multi-institutional collaborative policy on medical futility. JAMA 1996; 276(7):571-574

All the major hospitals in the Houston, TX area have joined together to develop a procedural policy outlining how they will respond to the situation where a patient or surrogate requests medically "inappropriate treatment." The article describes flawed definitions, flawed processes, and lack of an ethical framework which have been evident in previous attempts at futility policies. They then go on to give the wording and the justification for their joint effort.

Ethics Committee of the Society of Critical Care Medicine. Consensus statement of the SCCM's Ethics Committee regarding futile and other possibly inadvisable treatments. Critical Care Medicine 1997;25(5):887-91

"Treatments that are extremely unlikely to be beneficial, are extremely costly, or are of uncertain benefit may be considered inappropriate and hence inadvisable, but should not be labeled futile."

"Policies to limit inadvisable treatment should have the following characteristics: (a) be disclosed in the public record; (b) reflect moral values acceptable to the community; (c) not be based exclusively on prognostic scoring systems; (d) articulate appellate mechanisms; and (e) be recognized by the courts."

Council on Ethical and Judicial Affairs, AMA. Medical futility in end-of-life care. JAMA 1999;281(10):937-41

What constitutes futile interventions remains a point of controversy in the medical literature and in clinical practice. In clinical practice, controversy arises when the patient or proxy and the physician have discrepant values or goals of care. Since definitions of futile care are value laden, universal consensus on futile care is unlikely to be achieved. Rather, the AMA Council on Ethical and Judicial Affairs recommends a process-based approach to futility determinations. The process includes at least 4 steps aimed at deliberation and resolution including all involved parties, 2 steps aimed at securing alternatives in the case of irreconcilable differences, and a final step aimed at closure when all alternatives have been exhausted. The approach is placed in the context of the circumstances in which futility claims are made, the difficulties of defining medical futility, and a discussion of how best to implement a policy on futility.

Bibliography

Trotter G. Mediating Disputes and Medical Futility: Response to 'Bringing Clarity to the Futility Debate: Don't Use the Wrong Cases' by H. Brody and 'Commentary: Bringing Clarity to the Futility Debate: Are the Cases Wrong?' by L. J. Schneiderman. Cambridge Quarterly of Healthcare Ethics 1999;8(4):527-37.

In this article, the author responds to the thoughts of the above authors and discusses the concept of futility and the goals of medicine.

Blackhall LJ. Must we always use CPR? N Eng J Med. 1987; 317(20):1281-1285

"The issue of patient autonomy is irrelevant, however, when CPR has no potential benefit. Here the physician's duty to provide responsible medical care precludes CPR..."

Younger, SJ. Who defines futility? JAMA 1988; 260(14):2094-2095

"Physicians should not offer treatments that are physiologically futile or certain not to prolong life, and they could ethically refuse patient and family requests for such..."

Tomlinson T, Brody H. Futility and the ethics of resuscitation. JAMA 1990; 264(10):1276-80

"The authority to make a judgment about the balance of the harms and benefits of attempted resuscitation for the patient remains with the physician...We conclude that physicians must be able to employ reasonable, socially validated value judgments to restrict the alternatives offered to patients..."

Hackler JC, Hiller FC. Family consent to orders not to resuscitate. JAMA 1990; 264(10):1281-83

"Policies should be changed to allow physicians to write a DNR order over family objections when (1) the patient lacks decision-making capacity, (2) the burdens of treatment clearly outweigh the benefits, (3) the surrogate does not give an appropriate reason..., and (4) the physician has made serious efforts to communicate with the family and to mediate the disagreement."

Younger SJ. Futility in context. JAMA 1990; 264(10):1295-96

"...I think it is crucial that physicians inform patients and families when resuscitation efforts will not be made."

AMA Council on Ethical & Judicial Affairs. Guidelines for the appropriate use of do-not-resuscitate orders. JAMA 1991; 265(14):1868-71

"The physician has an ethical obligation to honor the resuscitation preferences expressed by the patient...However, if, in the judgment of the treating physician, CPR would be futile, the treating physician may enter a DNR order...the physician must first inform the patient...[and] should also be prepared to discuss appropriate alternatives..."

Lo B. Unanswered questions about DNR orders. JAMA 1991; 265(14):1874-75

"Framing the discussion of CPR in terms of futility is alluring because decisions seem objective, conflicts over values and goals are hidden, and physicians can take decision-making power."

Scofield GR. Is consent useful when resuscitation isn't? Hastings Center Report 1991;21(6):28-36

"Forging a consensus about matters of clinical and social importance requires trust and honesty, and the current posture of the debate suggests that no one trusts anyone to make these decisions. The truth is, however, that we must trust ourselves to make them together...conversing openly and respectfully with each other."

The Journal of the American Geriatrics Society (JAGS) August 1994 issue (vol 42, no 8) reports on a March 1993 Congress of Clinical Societies devoted to the question of FUTILITY:

- Fins JJ. Futility in clinical practice: report on a Congress of Clinical Societies. pp 861-65
- Callahan D. Necessity, futility, and the good society. pp 866-867
- Lantos JD. Futility assessments and the doctor-patient relationship. pp 868-870
- Veatch RM. Why physicians cannot determine if care is futile. pp 871-874
- Brody H. The physician's role in determining futility. pp 875-878
- Nelson JL. Families and futility. pp 879-882
- Schneiderman LJ. The futility debate: effective vs beneficial intervention. pp 883-886
- Youngner SJ. Applying futility: saying no is not enough. pp 887-889
- Murphy DJ. Can we set futile care policies? pp 890-893
- Cranford RE. Medical futility: transforming a clinical concept into legal and social policies. pp 894-898
- While LJ. Clinical uncertainty, medical futility and practice guidelines. pp 899-901
- Ackerman TJ. Futility judgments and therapeutic conversation [editorial]. pp 902-903
- Pearlman RA. Medical futility: where do we go from here? [editorial]. pp 904-905

Weijer C, Elliott C. Pulling the plug on futility. Br Med J 1995;310:683-684

"Patients do not have a right to treatment that falls outside the bounds of standard medical practice...But the concept of medical futility is a tarbaby. It cannot do what it is asked to do... ...both the doctor's judgment and that of the patient (or family) are essential to the decision making process... This can be achieved only by an open and frank dialogue."

Orr RD. The Gilgunn case: Courage and questions. Journal of Intensive Care Medicine 1999;14(1):54-6

The author responds with some support and some criticism to the first published report (in the same issue - Paris et al, pp 41-5) of the clinical details of a legal case in which physicians and hospital were found not liable for stopping treatment over the objections of family members.