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Medical Futility*

Committee on Ethics

ABSTRACT: The construct of medical futility has been used to justify a physician's unilateral refusal to provide treatment requested or demanded by a patient or the family of a patient. It is important that physicians and their institutions develop a process for dealing with conflict surrounding the construct of medical futility. Prospective policies on medical futility are preferable to unilateral decision making by individual physicians. When there is disagreement, patient and family values regarding treatment options and the default position of maintaining life ordinarily should take priority.

A proliferation in medical technology has dramatically increased the number of diagnostic and therapeutic options available in patient care. Health care costs also have increased as a byproduct of this technologic expansion. Simultaneously, medical ethics has undergone a rapid metamorphosis from a beneficence-focused ethic to one in which autonomy dominates: that is, from an ethic in which the physician attempted to determine what was in the patient's best interest and then acted on behalf of the patient to an ethic in which alternatives are presented to the patient and the patient makes the ultimate decision. Thus, both the physician and the patient may face the daunting task of selecting from among myriad highly technologic and expensive health care choices.

These choices, among other factors, have created situations in which patients or families have sometimes demanded care that physicians may deem futile, or incapable of producing a desired result. The construct of medical futility has been used to justify a physician's unilateral refusal to provide treatment requested or demanded by a patient or the family of a patient. Such decisions may be based on the physician's perception of the inability of treatment to achieve a physiologic goal, to attain other

goals of the patient or family, or to achieve a reasonable quality of life.

Although there is general agreement with the notion that physicians are not obligated to provide futile care (1), there is vigorous debate and little agreement on the definition of futile care, the appropriate determinants of each component of the definition, and on whose values should determine the definition of futility. Proposed definitions of medical futility include one or more of the following elements:

- The patient has a lethal diagnosis or prognosis of imminent death.
- Evidence exists that the suggested therapy cannot achieve its physiologic goal.
- Evidence exists that the suggested therapy will not or cannot achieve the patient's or family's stated goals.
- Evidence exists that the suggested therapy will not or cannot extend the patient's life span.
- Evidence exists that the suggested therapy will not or cannot enhance the patient's quality of life.

The following questions need to be addressed concerning each of the previously identified elements:

- What is imminent death? Is it death that is expected within hours or days, or



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*Update of "Medical Futility," in *Ethics in Obstetrics and Gynecology*, Second Edition, 2004.

would it include death expected at any time up to 6 months or longer?

- At what point can a therapy be defined as unable to achieve a physiologic goal? Is futility reached when the goal could never be achieved or when the goal could be achieved in less than 1% of the cases, in 5% of the cases, or within some other established limit?
- What defines when a therapy can no longer achieve the patient's or family's goals, and who should decide this?
- What constitutes an enhanced life span—1 day, 1 week, 1 month?
- How is quality of life measured, and who should determine what constitutes a satisfactory quality of life for a given patient?

What these definitions have in common is an assessment of whether a particular therapy will be effective (ie, that it might alter the course of the disease or symptoms of the patient), whether it offers any benefit to the patient, and whether it adds to the burdens suffered by the patient (2). It is important to note that the concept of futility does not apply exclusively to situations in which a patient has a terminal illness, but can apply to any clinical situation in which a proposed treatment offers virtually no chance of achieving a desired result. For example, futility would be a sufficient reason to refuse in vitro fertilization treatments to a couple who wishes to use their own gametes when the female partner is older than 50 years and has a markedly elevated follicle-stimulating hormone level (3).

Disagreements will sometimes occur between stakeholders in the decision about whether a therapy will be considered futile or not. These disagreements may concern the definition of futility or whether the conditions to establish futility have been met. These differences frequently arise because one party places a different value on one possible outcome of the therapy than the other party.

For example, a patient may judge that even one more day of life is worth a therapeutic attempt or that living in a coma is more desirable than death, while a physician caring for that patient may feel differently. Physicians or society may be less willing to provide the requested care as they balance the use of resources and their individual or collective view of the potential for and degree of benefit. Patients may not include the use of resources in their equation at all but simply balance negative side effects and risks against the likelihood and degree of a beneficial outcome. Society may be more likely to accede to patient wishes when the use of resources is minimal than when it is significant, regardless of the likelihood of achieving physiologic goals, increasing life span, or achieving patient goals. Reasonableness and equity in the distribution of resources may play a role in determining whether societal and institutional values should prevail in contested decisions. When resource distribution is an issue, however, the values of the patient and the preservation of life ordinarily take priority and are ethical default positions.

Ultimately, these are differences of value, with individuals placing different values on the likelihood of a good outcome, different assessments of what would constitute an acceptable outcome, and different views about how much effort and expense can be justified in the pursuit of an unlikely outcome. Consensus is most likely in situations where the likelihood of achieving an outcome that anyone would consider valuable is very low. One suggestion has been that most physicians could agree that something was futile if it had not worked in the previous 100 similar cases (4).

Litigation also has generally resulted in courts supporting the views of patient or family in cases in which patient and caregiver disagree regarding withholding care, at least when withholding or withdrawing a medical treatment would likely result in the death of the patient (5–9). Commentators have observed that court decisions in favor of patient or family wishes appear to be based on one of the following factors:

- Medicine's inability to quantify the likelihood of futility with certainty
- The lack of a prospective and clearly stated process for determining medical futility
- The courts' current bias toward autonomy
- A desire to be consistent in upholding the patient's rights whether the patient is refusing or requesting treatment
- Recognition that withdrawal of life-sustaining care would likely result in the death of the patient

Need for a Medical Futility Policy

Inability to achieve a physiologic goal—strict physiologic futility—is an appropriate basis for a physician to refuse to provide requested therapeutic intervention. However, the ability to declare strict physiologic futility with certainty exists in only a limited number of clinical situations in which there are conflicts about whether to continue a therapy.

Other interpretations of medical futility are too subjective to form the basis for unilateral physician decisions. Therefore, in the absence of strict physiologic futility, the construct of medical futility should be applied only according to a prospective organizational policy that provides a process rather than a rule for resolving conflict.

The preferred approach for resolving all disputes about whether a particular therapy should be offered or continued should first be communication between the patient and the physician. This conversation should focus on reasonable goals of treatment, with emphasis on whether the therapy in question can, in fact, achieve the therapeutic goals set by the patient and physician (10). The discussion should focus on specific clinical problems, goals, and therapies rather than on whether the family wants “everything done,” which represents a meaningless and misleading request or offer. If resolution cannot be

achieved through provider–patient communication, an ethics consultant or ethics committee should be involved to assist in the resolution of the dispute.

A policy can be valuable in those situations in which the probability of reaching a physiologic goal or the potential for enhancement of life's duration or quality is remote and there is disparity in the subjective interpretations by patient (family), physician, institution, and society regarding the cost (economic, physical, emotional) versus benefit ratio. A medical futility policy should emphasize communication and negotiation rather than unilateral physician decision making.

Designing a Medical Futility Policy

A medical futility policy should be built on the following foundations:

- It should be designed to enhance discussion among the parties.
 - The responsible physician should be encouraged to involve all appropriate members of the treatment team (eg, house staff, nurses, and social workers) to help reach an agreement between the patient (or surrogate), the physician, and other members of the health care team.
 - It should be designed to seek input from other individuals or groups with expertise in the relevant medical discipline or medical ethics (including clergy, attorneys, and ethics committees).
 - It should include some formal institutional mechanism for conflict resolution, such as ethics consultation or an ethics committee that ensures a thorough review of the institution and provides a fair hearing for all stakeholders.
 - It should allow a patient to select another caregiver whose view is more consistent with her own and facilitate transfer of care, without prejudice, by the original physician.
 - If transfer of care is arranged, all ongoing, life-sustaining treatment and interventions must be continued while the transfer is awaited.
 - If no conciliation of views or patient transfer occurs, or if no other caregiver or facility is willing to provide the desired treatment, the caregivers are not required to provide care that they regard as medically futile.
 - There must be some process of appeal as the situation comes closer to action by the physician or facility that is still contested by the patient or family.
 - When caregivers refuse to provide a futile intervention or abrogate a certain aspect of treatment on the basis of its futility, their obligation to provide care is undiminished. Providing comfort care and palliative care and maximizing quality of life at the end of life remain fundamental obligations of the physician responsible for a patient's care.
- The policy should require documentation that includes the following information:
 - Probable diagnoses
 - Probable prognosis
 - Physician-recommended alternatives
 - Patient-desired pathway
 - Process of decision making that was followed, including notes from relevant meetings

An example of a policy that provides a process for decision making in medical futility is outlined in the American Medical Association Council on Ethical and Judicial Affairs report, "Medical Futility in End-of-Life Care" (1) (see <http://jama.ama-assn.org/cgi/reprint/281/10/937> for a decision tree). Other institutions have published their policies (11), and at least one state (Texas) provides a law that outlines the conditions under which a treatment team or institution can unilaterally withhold or withdraw a therapy that has been deemed futile. These conditions include 1) notifying the patient or the person responsible for the health care decisions of the patient in writing about the hospital's policy on ethics consultation, 2) providing the patient or responsible person with 48-hour notice of consultation and inviting him or her to participate in the consultation, and 3) providing the patient or responsible person with a written report of the ethics review process.

Under Texas law, when the ethics consultation process fails to resolve the dispute, the hospital must work with the patient or responsible person to try to arrange transfer to an institution or physician that will provide the disputed therapy. If no provider can be found after 10 days, the therapy can be unilaterally withheld or withdrawn. A judicial appeal for an extension beyond 10 days can be made by the patient or responsible person, but it can be granted only if the judge determines there is a reasonable likelihood of finding a provider willing to provide the disputed treatment. When these conditions are met, the treatment team and institution receive immunity from civil or criminal prosecution (12).

Summary

It is difficult to define medical futility prospectively and objectively. Nonetheless, as technology continues to advance and use more resources, it is important that physicians and their institutions develop a process for dealing with conflict surrounding the construct of medical futility.

Prospective policies on medical futility are preferable to unilateral decision making by individual physicians. Such a medical futility policy should provide a systematic process for dealing with disagreements, for ensuring that all parties have received a fair hearing, and for reaching a fair resolution, as outlined previously. When there is disagreement, patient and family values regarding treatment options and the default position of maintaining life ordi-

narily should take priority. However, situations may occur in which claims of reasonableness and equity in the distribution of resources are so powerful that the views of caregivers, the institution, and society will prevail.

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