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Ethical Issues: Futility Policies

Futility, in general, is the inability to achieve an intended goal or outcome. Biomedical futility more specifically is a clinical judgment that, in light of the patient's current clinical circumstance, it is not physiologically possible for an intervention to achieve its intended and predictable biomedical and therapeutic goals; therefore the proposed intervention would be medically ineffective.

Traditionally physicians have been trained to unilaterally, and sometimes paternalistically, avoid treatment of untreatable diseases and to avoid harm by useless efforts.[i] Decisions about when and how to treat patients who are "beyond hope" are guided by the physician's skill and knowledge, and the benevolent precepts of the medical profession that require us to attend to the patient's needs. Futility for the most part in the clinical setting has been objectively defined as "biomedical futility" by means of a unilateral appraisal of probably clinical outcome made by the physician and based on clinical evidence, experience, and probability.

The unilateral professional ability to make treatment decisions changed dramatically in the 1970s as patients began challenging physicians' right to make decisions unilaterally. Patients often now demand that they be the determiners of their own fate. Futility began appearing in the medical literature as an ethical concern in the late 1980s by which time the ability to sustain life in the face of serious and life threatening illness had become much less limited. Subsequently rapidly advancing developments in medical technology and the sophistication of intensive care units provided the capability of keeping patients alive seemingly indefinitely. In response, patients (as well as many physicians) began voicing concern that many patients were being kept alive well beyond what they might consider to be a reasonable quality of existence.[ii][iii] Futility, no longer defined solely by the physician in terms of medical success or failure, is now dependent on, and for the most part seems to be dominated by, patient preferences, values, and beliefs.

The ability to delineate between "ordinary" and "extraordinary" treatments has also become increasingly difficult for medical science. Continued medical advancement and therapeutic success began to blur the ability to define biomedical futility because there has been no agreement in the medical community about underlying precepts that determine futility.[iv] From 1995 to 1999 the number of articles published in the medical literature dealing with question of futility dwindled from 134 to 31, underscoring the general academic malaise arising in dealing with a question that seemingly could not be answered. Many physicians and theorists have argued that the concept of futility may be indefinable and no longer pertinent in the modern paradigm of health care due to the capacity of modern medicine and the expectation of most patients to be treated.[v]

Opposing this view is the belief that the very nature of illness and unavoidable death is universal and still requires consideration of values and beliefs of all stakeholders as objective criteria in determining if and when treatment is worthwhile.

Medically ineffective treatment means that, to a reasonable degree of medical certainty, it is not possible for the proposed intervention to: 1) prevent or reduce the deterioration of the health of an individual; or 2) prevent the impending death of an individual; or 3) effectively or appreciably alter the course of disease. Biomedical futility *per se* does not take into consideration the beliefs and preferences of the patient, but it cannot avoid being influenced by the moral agency of the physician whose moral precepts are closely defined by their training and a sense of professional obligation to always treat disease. A judgment that, though the intervention has a reasonable possibility of biomedical success, it should not be done because the quality of patient's life would be poor, does not constitute biomedical futility under this definition.

Hospital policies addressing futility and the withholding and withdrawing of treatment have been written, discussed, and implemented at MU Health Care, as they have in several other hospitals across the nation.[vi] Futility policies such as these are intended for use by the clinician as guidelines for decision making about futile treatment. As with any hospital policy regarding patient care they should be utilized cautiously so as not to depersonalize decision making by removing it from the bedside or in any way erode the trust relationship that the patient has with her physician.

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[i] Hippocrates. *On the art* in *Hippocrates*, vol. 2, tr. W.H.S. Jones, Loeb Classical Library. Cambridge: Harvard Univ. Press. [1923] 1981; pp 193, 205.

[ii] The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. *Deciding to forego life-sustaining treatment: A report on the ethical, medical and legal issues in treatment decisions.* Washington, DC: U.S. Government Printing Office; 1983.

[iii] In re Quinlan, 355 A.2d 647, 1976.

[iv] Jonsen A. *The birth of bioethics*. New York: Oxford University Press; 1998.

[v] Helft PR, Siegler M, and Lantos J. The rise and fall of the futility movement. *NEJM*, 2000; 343(4): 293-296.

[vi] *Docushare*: policies on *Futility* and *Withholding/Withdrawing Treatment*