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A New Approach to the Issue of Medical Futility: Reframing the Debate

Sophie Kasimow

The 1960s saw the birth of the newest field in the ethics of healthcare and the biomedical sciences: bioethics. The revolutionary technological advances during this and the following decades – including the creation and widespread use of dialysis machines, artificial ventilators, in vitro fertilization, modern contraception, and organ transplants – created new ethical problems that had never before been encountered. As these technologies developed, people began asking questions about their proper use. With the new capacity to keep the bodies of “dead” patients working for days, months, or even years, bioethicists had new dilemmas on their hands. By the 1980s, physicians began to identify that they could maintain physiological processes of life but not reverse existing bodily damage. In an increasing number of patients, doctors felt they were prolonging death with nonbeneficial or even harmful treatments.¹ This issue of medical futility has become a growing problem for hospitals; in the United States alone it is estimated that there are currently 14,000-35,000 people in a persistent vegetative state (PVS), and this number does not include the potentially thousands of other patients who are comatose but do not meet the recognized criteria for brain death.²

¹ Gay Moldow, Dianne Bartels, Don Brunnquell, and Ron Cranford, “Why Address Medical Futility Now?,” *Minnesota Medicine* (June 2004), 38.

² The Multi-Society Task Force on PVS. “Medical Aspects of the Persistent Vegetative State: First of Two Parts,” *New England Journal of Medicine*, vol. 330 (1994), 1499-1508.

In this paper I will lay out the foundation of the medical futility debate, using Mark Wicclair's article, "Medical Futility: A Conceptual and Ethical Analysis," published in *Biomedical Ethics*, by Thomas Mappes and David DeGrazia.³ After discussing some of the concerns that arise with the available literature on the futility conversation, I will develop my own working definition for medical futility. After reading this paper, I hope that doctors and bioethicists will gain a greater understanding of the difficulties of declaring a treatment futile, as well as improve their ability to consider the ethical questions raised throughout the treatment of a dying patient.

The word "futility" comes from the Latin word for leaky (*futilis*), and can be found in ancient texts such as the Greek myth of the daughters of Danaus who were condemned for eternity in Hades to draw water in leaky buckets. A futile action, as exemplified in this story, is one that will never achieve the goals of the action, no matter for how long or how often it is repeated.⁴ To deem a medical treatment futile requires considerable clarification.

In order to understand the idea of medical futility, it is important to recognize the difference between futility and impossibility. For example, it is physically impossible to restart a heart if the person does not have enough blood in their body. Futility is also often confused with extremely complex acts that are implausible, though perhaps theoretically possible. For example, though it is conceivably possible, it is currently too complicated for humans to produce a baby

³ Mark R. Wicclair, "Medical Futility: A Conceptual and Ethical Analysis," in Thomas A. Mappes and David DeGrazia, *Biomedical Ethics*, 4th Ed. (New York, USA: McGraw-Hill, Inc., 1996), 346.

⁴ Lawrence J. Schneiderman, Nancy S. Jecker, and Albert R. Jonsen, "Medical Futility: Its Meaning and Ethical Implications," *Annals of Internal Medicine*, vol. 112 (June 1990), 950.

entirely outside of the womb.⁵ It should also be clarified that a futile action is not futile on the basis of its rarity or unusualness, such as the highly unlikely success of returning to health a mentally impaired drug addict with bacterial endocarditis (an infection of the heart). Rather, an action is futile because it will fail in its goals. These are often difficult distinctions to make as medical cases become increasingly complicated, and it will be useful to refer to them later if the need for clarification arises.

Since the beginning of the futility debate, doctors and ethicists have been dividing out the necessary conditions of futility in different ways. Mark Wicclair presents the idea that futility has three different senses: 1) Physiological futility, 2) Futility in relation to the patient's goals, and 3) Futility in relation to standards of professional integrity.⁶

Physiological futility is the aspect of futility that asserts that certain medical interventions will not achieve their medical goals. Under this sense of futility, an action such as tube-feeding is futile if it will not succeed in providing sustaining nutrition. In this type of case, those with the greatest clinical expertise (doctors) will be the ones most likely to know the effects of a medical intervention, and whether or not that intervention will achieve the desired medical outcome.⁷

Several concerns arise when considering the idea of physiological futility. First, though doctors may understand whether the outcome will be successful, determining whether the outcome is an appropriate

⁵ Lawrence J. Schneiderman, Nancy S. Jecker, and Albert R. Jonsen, "Medical Futility: Its Meaning and Ethical Implications," *Annals of Internal Medicine*, vol. 112 (June 1990), 950.

⁶ Mark R. Wicclair, "Medical Futility: A Conceptual and Ethical Analysis," in *Biomedical Ethics*, 4th Ed., 346.

⁷ *Ibid.*, 347.

objective in the first place requires value judgments that go beyond the scope of their position. A doctor could consider that surgery X will not prevent further illness nor reduce pain and so is medically futile, while the patient may have other objectives in mind and so desire the surgery. Some types of cosmetic surgery may raise this objection, for example. Secondly, doctors may decide that a treatment is medically futile based on their expertise in relation to a standard of reasonableness, such as reasonable past success of that treatment. Again, a value judgment is required when deciding what constitutes a “reasonable” chance of success. Additionally, certain treatments cause benefits and negative effects simultaneously, and it is difficult to create a guide for handling these borderline cases.

The second sense in which medical futility is categorized by Wicclair is the idea that a treatment is futile if it will not achieve the goals of the patient.⁸ While physicians can help the patient clarify his or her goals, perhaps through an explanation of physiological processes, they cannot choose which goals a patient should hold. When a doctor understands the goals of the patient, he or she can present the patient with the best possible options for continuing care. Does the patient wish to undergo a painful procedure with a low likelihood of success, or is the goal of the patient to have a potentially shorter, but less painful life? The patient must be asked if the treatment is, in their opinion, “worth the effort.”

There are two major problems with this aspect of futility. First, patients and/or their surrogates may disagree with the doctor’s opinion regarding the probability of achieving their goal through the treatment in discussion. The patient may feel they are healthy and of a strong mind and so will “beat the

⁸ *Ibid.*, 348.

odds.” Secondly, even if the doctor and patient agree on the probability of the treatment being a success, they may disagree on whether that percentage is worth the risk. Patients often desire treatments despite their poor odds. From personal experience, I have found that when a patient is faced with doing nothing or doing something that has a low probability of success, if the treatment is bearable they will generally desire to give it a try. This objection returns us to one of the objections to physiological futility; namely, that deciding what can be categorized as a “reasonable” probability, success, or outcome is a personal value judgment.

Wicclair’s third division of medical futility, futility in relation to standards of professional integrity, addresses the idea that a treatment is futile if there is no reasonable chance it will achieve any goals that are consistent with the rules of professional integrity. Though I find this measurement of “professional integrity” more ambiguous and difficult to explain than the first two divisions of futility, Wicclair is trying to get at the idea that there are proper goals of medicine and appropriate uses of certain medical interventions. Physicians must maintain the integrity of their discipline by using treatments sensibly. These standards prevent doctors from providing services that are contrary to the standards of other physicians. A doctor could argue that providing CPR for a patient with heart failure is futile because the patient has a less than 1 percent chance of surviving long enough to leave the hospital. While the patient may request CPR in case of cardiopulmonary arrest, the doctor may claim that providing CPR is a misuse of the treatment, and that providing that treatment would violate the doctor’s professional integrity. In cases where professional integrity indicates a treatment may be futile, what specific aspect of integrity is being cited? Is the doctor

using his or her own personal standards regarding CPR or widely accepted standards?

These questions raise, once again, the same problem of relativism that the other two aspects of futility face. Wicclair argues that futility judgments using this third sense are only justified if they are legitimate standards within the medical profession. While certain standards can be discussed in advance, a large portion of the discussions in cases of medical futility is a discussion of quality of life and is different for each individual patient and their family. If we accept this qualitative component to the discussion of medical futility, which I do accept, then “why should the patient not always decide whether the quality achieved is satisfactory or not? Why should qualitatively “futile” results not be offered to the patient as an option?”⁹ This is a contentious subject in the medical futility literature; doctors declaring a treatment futile has been construed as medical professionals asserting their power over the autonomy of the patient. This perspective, that the autonomy of the physician supercedes the autonomy of the patient, is based on the idea that doctors and patients are involved in a continuing power-struggle for control, with doctors having the upper hand. Declaring a treatment futile is not a “trump card” in this relationship, but rather a necessary part of the physician’s duty of beneficence. Futility must not be declared arbitrarily, but rather established within the medical discipline to preserve professional standards.¹⁰ When everything has been done and a patient is dying, through further treatment

⁹ Lawrence J. Schneiderman, Nancy S. Jecker, and Albert R. Jonsen, “Medical Futility: Its Meaning and Ethical Implications,” 952.

¹⁰ Lawrence J. Schneiderman, Nancy S. Jecker, and Albert R. Jonsen, “Medical Futility: Response to Critiques,” *Annals of Internal Medicine*, vol. 125 (15 October 1996), 670.

may be declared futile, continuing palliative care is never futile.¹¹

Using Wicclair's divisions of futility as a guideline, I propose this working definition of medical futility: *A treatment should be considered futile if it will not be beneficial to the physiological or psychological health of the patient.* This definition states that a treatment is futile if it will not solve the medical problem, and also incorporates the idea that a treatment may not be futile if the treatment is important to the patient's goals. Acknowledging that it is possible for an individual to have goals that are non-health promoting, the idea of treatment promoting a patient's "psychological health" is based on the rational that a mentally healthy and competent adult will not generally desire treatment that is deleterious to their health. The patient may desire treatment that will prolong their life at a quality that may not be seen as particularly desirable, but most patients are motivated to continue further treatment to prolong their healthy life, not prolong a life in PVS, for example. This assumption may be challenged, though the risks of defining futility solely in terms of a patient's goals and desires raise many additional ethical challenges, some of which I have raised in this paper.

My definition excludes Wicclair's notion of professional integrity because it is even more arbitrary than what may arguably be seen as a definition that is too vague to be useful. If the medical team could gain a better understanding of the patient and/or their family's reasoning, perhaps the lines of communication would be more productive. A mutually acceptable decision might be easier to reach; patients and families would feel less powerless to get what they need, and the

¹¹ Dianne Bartels. Minnesota Center for Bioethics, MN. Conversation, 2004.

doctors would feel less conflicted about providing care that they feel is futile or unethical.

Patients and families who must make treatment decisions when the case is deemed futile – meaning that the treatment will not benefit the patient either physiologically or psychologically – have a difficult task and many emotions to balance. As medicine continues to advance, and patients are revived from progressively more dire conditions, it will become increasingly important to understand the concepts central to the medical futility discussion.