FAST FACTS & CONCEPTS

Medical Futility

Joy E Cuezze MD, Christian T Sinclair MD

Medical futility is commonly used by health professionals in reference to the appropriateness of a medical treatment option. Increasingly hospitals and nursing homes are developing their own futility policies and Texas has developed a statewide futility policy. This Fast Fact will explore bioethical issues with the term futility and as well as recommendations from the American Medical Association (AMA) on how to approach medical futility concerns.

The Problem with 'Futility'

The public, policymakers, ethicists, and the medical profession have been unable to agree on a clear, concise definition of futility that can be applied to all medical situations. One commonly used definition is that a futile intervention is one that a) is unlikely to be of any benefit to a particular patient in a particular medical situation, and b) will not achieve the patient's intended goals. The sticking point in all futility definitions is the concept of benefit, as the perception of benefit is highly subjective. Physicians, patients and families often have very different views on what is potentially beneficial. For example, a physician may believe that renal dialysis in an elderly demented patient is futile, while the family that views preservation of life at all costs as part of their cultural ethos, may view dialysis as a beneficial intervention. Furthermore, medical futility can be easily misunderstood as health care rationing. While economic issues may impact shared decision making, the ultimate question is not How much does this therapy cost? Rather, it is Do the advantages of this therapy outweigh the disadvantages in a given patient?

Types of 'Futility'

Quantitative futility refers to the intervention that has a very small chance of benefiting the patient; the most commonly used number is less than 1% chance of success. Qualitative futility describes a situation in which the quality of benefit an intervention will produce is exceedingly poor. However, neither approach is adequate as there is no consensus on either numeric thresholds for quantitative futility nor shared understanding of what constitutes qualitative benefits.

Medical Futility Policies

Despite these challenges with the concept of medical futility, many large organizations recommend that health care institutions adopt a clear policy that outlines a due process for approaching futility disputes which provides both patient protections and clinician options in cases where continuing life-prolonging treatments serves no appreciable medical benefit. Suggestions from an AMA Council on Ethical and Judicial Affairs on the content of such a medical futility policy include:

- Earnest attempts should be made in advance to negotiate between patient, proxy, and physician on what constitutes futile care for the patient.
- Joint decision making between patient or proxy and physician should occur to the maximum extent.
- Assistance of consultants such as ethics committees should be pursued to negotiate disagreements.
- If a dispute remains unresolved and the institutional review supports the patient's position and the physician is unpersuaded, transfer of care to another physician within the institution may be arranged.
- If the institutional review supports the physician's position and the patient remains unpersuaded, transfer to another institution should be sought.
- If no transfer of care can be arranged, halting futile treatment is ethically acceptable.

Institutional Medical Futility Policies Although recommended by the AMA (see above), most hospitals do not have a medical futility policy outlining a process of resolution. Since physicians are not legally, professionally or ethically required to offer medically futile treatments, a defined policy can serve as a method to outline a clear process that honors both patient rights and clinician professionalism.

Other Suggestions

- Check with your health care institution regarding the presence of an existing futility policy.
- Ethics committees and medical organizations (local/state/national) can provide resources to understand medical futility and professional responsibilities in one's practice area.
- Avoid using the term 'futility' in discussion with patients/families. Rather, speak in terms of 'benefits'/'burdens' of treatment and patient or family-specific goals of care.
- Involve a palliative care and/or ethics consultant in any situation where 'futility' will be invoked as a process step in formulating decisions.

REFERENCES

1. **Doty WD, Walker RM.** Medical Futility. Clinical Cardiology. 2000; 23(2 Suppl 2):II6-II16.
2. **Schneiderman LJ, Jecker NS, Jonsen AR.** Medical futility: its meaning and ethical implications. Ann Int Med. 1990; 112:949-954.
3. **Cantor MD, et al.** Do not resuscitate orders and medical futility. Arch Intern Med. 2003; 163:2689-2694.
4. **American Medical Association.** Opinion 2.037: Medical Futility in End-of-Life Care. JAMA. 1999; 281: 937-41. Accessed November 13th, 2015 at: https://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2037.page

Version History This Fast Fact was originally edited by David E Weissman MD and published in April 2005. Version re-copy-edited in April 2009. Major revision occurred in February 2015 by Sean Marks MD to incorporate reference #4.