Medical Futility:
A Quick Tour

Seeking to Achieve a Standard of Practice
Healthcare Spending as % GDP

Note: For countries not reporting 2006 data, data from previous years is substituted.
Futility
Is It a Definable Concept?

Definition: “Leaky, vain, failing of the desired end through intrinsic defect” (OED)

futilis = ancient religious vessel that tipped over easily.
Futility
The Classical Period (300-400 BC)

Quantitative (Hippocratic)
- Whenever the illness is too strong for the available remedies, the physicians surely must not even expect that it can be overcome by medicine.
- To attempt futile treatment is to display an ignorance that is allied to madness.

Qualitative (Platonic-Asclepian)
- For those whose lives were always in a state of inner sickness (Asclepius) did not attempt to prescribe a regimen... to make their life a prolonged misery.
- A life of preoccupation with illness and neglect of work isn’t worth living.
Futility:
Late Middle Ages (1300-1500 AD)

Health and Illness are rewards and punishments of
God

Age of supernaturalism and superstition
Prayer, laying on of hands, exorcisings, amulets
with sacred engravings, holy oil, relics of the
saints, miracles
Futility:
Enlightenment (1600-1800 AD)

Goal of science: Not merely to “exert a gentle guidance over nature’s course” but to “conquer and subdue her.”  
Francis Bacon
Futility:
19th Century

“If the whole materia medica, as now used, could be sunk to the bottom of the sea, it would be all the better for mankind--and the worse for the fishes.”

O.W. Holmes “Homeopathy and Its Kindred Delusions”
“Decisions to limit access to care deemed futile should not rest with medical professionals.”
Veatch & Spicer

“Physiologic futility, understood in narrow terms, comes close to providing a value-free understanding of futility.”
Truog, Brett, Frader
Futility: Modern & Post-Modern (1960s-2000s AD)

1972

Society of Critical Care Medicine

End Stage Renal Disease Program

Persistent Vegetative State
Futility: Modern & Post-Modern (1960s-2000s AD)

“It is important that clinicians remain visibly open to the possibility of contrary judgments by the family on behalf of the patient--to the possibility for example, that odds of one chance in a thousand of a favorable outcome might be consistent with the patient’s values…”

Curtis, Burt

“It is difficult to specify limits beyond which treatment should be withheld when there is any chance that a life can be saved. However, if we cannot agree that treating 400 patients with prolonged intensive care without producing a single survivor is beyond such a limit, then it is unlikely we can reach a consensus about limiting care in any clinical situation.”

Rubenfeld & Crawford
“The rapid advance of the language of futility into the jargon of bioethics should be followed by an equally rapid retreat.”

Truog, Frader

“Those who call for the abandonment of the concept have no substitute to offer. They persist in making decisions with, more or less, covert definitions. The common sense notion that a time does come for all of us when death or disability exceeds our medical powers cannot be denied. This means that some operative way of making a decision when ‘enough is enough’ is necessary. It is a mark of our mortality that we shall die. For each of us some determination of futility by any other name will become a reality.”

Pellegrino
Futility: Modern & Post-Modern (1960s-2000s AD)

“Neurologically devastated” 2 year old; father’s “unyielding refusal to consider” DNAR; “multiple unsuccessful attempts to place central venous and intraosseus lines”; nurse found it “so upsetting she had had to fight back the urge to vomit;” father looked at “all the puncture wounds and bruises” from failed attempts, said, “I want to thank you. I can see from this that you really tried.” Truog, 2010

“When…physicians acquiesce to family demands for nonbeneficial treatment at life’s end, we use the patient as a means to the family’s end, while strengthening the mistaken cultural belief that dying and death are medical problems to be solved rather than spiritual problems to be faced. This serves neither patients nor families well.” Fine, 2010

“It is as if the ‘last rites’ once performed by the priest have morphed into the ‘last rights’ of the dying patient to be accompanied on the final stages of life’s journey by a swarm of doctors and nurses administering epinephrine, chest compressions and intubations.” Paris, et al., 2010
What is Your Position on the Futility Debate?

• Isn’t futility a value-laden term and shouldn’t only a value-free or strict physiologic definition be used?
  - Physiologic futility is not value free but a value choice, which departs dramatically from the patient-centered goals of medicine, and has delayed medicine’s appreciation of the importance of good end-of-life care.

• Doesn’t the patient have the right to obtain any desired treatment?
  – Physicians cannot legally prescribe anabolic steroids to a patient who wishes to become a world-class body builder.
What is Your Position on the Futility Debate?

• How can the physician be “absolutely certain” a treatment won’t work and produce a miracle?
  – The physician can never be absolutely certain. Only reasonably certain at best. Is the physician obligated to seek a miracle?

• What if the patient (or more usually the family) insist on “doing everything” even if there is only one in a thousand chance of it working?
  – Remember the denominator: the 999 times it will cause useless suffering and violate the principle: First do no harm.
What is Your Position on the Futility Debate?

- Isn’t it true that no universal definition has been achieved with regard to medical futility?
  - Hospital policies and statutes are developing a majority and “respectable minority” standard of practice.
Futility

Quantitative

- We can never say never, right? (The problem of uncertainty in Medicine) Can we agree that if a treatment has not worked in the last 100 cases almost certainly it is futile? (upper limit of 95% CI=3%) If so, then the ordinary duty of the physician does not require offering this treatment.

- “…the BLS [Basic Life Support] rule had a positive predictive value for predicting lack of survival, which is within the acceptable range used by medical ethicists for defining futility.”

Futility

Qualitative

• Goal of Medicine is not merely to provide an effect, but a benefit (which can be appreciated by the patient). Therefore, treatment is futile if:
  – Patient remains in permanent vegetative state (biological survival without conscious autonomy).
  – Patient cannot survive outside the ICU or acute care hospital (Preoccupied with treatment and can achieve no other life goals).
Futility

Expand decision-making from narrow considerations of life-sustaining treatments (what we will not do) to ethic of care (what we will do).

Intensive Caring

- Alleviating pain
- Maximizing control
- Allowing for privacy, intimacy, dignity
- Addressing spiritual needs
- Fostering positive memories for loved ones
Is there a standard of practice regarding medical futility?

“Physicians must . . . not only set standards for medical practice, but also follow them. Physicians cannot expect parents, trial-court judges, insurance companies, or government regulators to take practice standards more seriously than they already do themselves.

Annas
Is there a standard of practice regarding medical futility?

- A health care provider or institution may decline to comply with an individual instruction or health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution.

- “Medically ineffective health care,” as used in this section, means treatment which would not offer the patient any significant benefit.

Uniform Health-Care Decisions Act (1994), California Probate Code (2003), Tennessee Health Care Decisions Act (2004), and also Alabama, Alaska, Delaware, Hawaii, Maine, Mississippi, New Mexico…
Is there a standard of practice regarding medical futility?

AMA Code of Medical Ethics, 1996

All health care institutions, whether large or small, should adopt a policy on medical futility.

• Policies on medical futility should follow due process in specific cases:
  a) Earnest attempts to deliberate and negotiate what constitutes futile treatment and what falls within acceptable limits for physician/family/institution.
  b) Joint decision-making to maximum extent possible.
  c) Negotiations with help of consultants as appropriate.
  d) Involvement of ethics committee if disagreements are irresolvable.
  e) If review supports patient v unpersuaded physician, arrange transfer within institution.
  f) If review supports physician v unpersuaded patient, seek transfer to another institution.
  g) If transfer not possible, the intervention need not be offered.
Is there a standard of practice regarding medical futility?

Medical Futility and the Texas Advance Directive Act of 1999

1. The family must be given written information re ethics consultation.
2. 48 hours’ notice and invitation to participate in the ethics consultation.
3. Written report to the family of the findings of the ethics consultation.
4. If dispute is not resolved, the hospital, working with the family, must try to arrange transfer to another provider physician and institution.
5. If after 10 days, no provider can be found, the physician may unilaterally withhold or withdraw the treatment that has been determined is futile.
6. The party that disagrees may appeal to state court for an extension of time before treatment is withdrawn. This extension is to be granted only if the judge determines that there is a reasonable likelihood of finding a willing provider of disputed treatment if more time is granted.
7. **If either the family does not seek an extension or the judge fails to grant one, futile treatment may be unilaterally withdrawn by the treatment team with immunity from civil and criminal prosecution.** (This is the “legal safe harbor” for physicians, institutions, and ethics committees, the first of its kind in the country.)
Medical Futility: Seeking a Community Standard

Greater Houston area (1996): “Procedural policy”…futility “cannot be meaningfully defined.”

“To establish a procedure for a decision, after all, is to recognize implicitly that something must be decided in an orderly way. The procedure itself is only a means. Unavoidably, it must turn on some set of criteria for action.”

Pellegrino
Medical Futility: Seeking a Community Standard

California Hospitals (1998):

39 hospital ethics committees represented
30 physicians
15 attorneys
5 judges
12 others (nurses, clergy, social workers, community representatives)

All but 2 of 24 hospital futility policies define nonobligatory treatment in terms of benefit to the patient rather than physiology, some with specific examples, e.g., dependence on ICU treatment.

Provides basis for definitional standard that justifies futility decision, and for “respectable minority.”
Medical Futility: Seeking a Community Standard

UCSD Medical Center:
Any treatment without a realistic chance of providing an effect that the patient would ever have the capacity to appreciate as a benefit, such as merely preserving the physiologic functions of a permanently unconsciousness patient, or has no realistic chance of achieving the medical goal of returning the patient to a level of health that permits survival outside the acute care setting of UCSD Medical Center.

University of Minnesota Medical Center Model Policy:
“Intervention is considered futile if it will not achieve its intended short or long term physiological goal, or has no realistic chance of achieving the medical goal of returning the patient to the level of health that permits survival outside the acute care setting.”

San Francisco Bay Area:
Non beneficial treatment is any treatment that, in the best judgment of medical professionals, produces effects that cannot reasonably be expected to be experienced by the patient as beneficial, or to accomplish the patient’s expressed and recognized medical goals, and/or will probably cause harm that outweighs any expected benefits. Potential examples...a patients who is irreversibly unconscious...a patient who has no realistic chance of surviving outside an acute care hospital intensive care unit.
Comfort Care

UCSD Medical Center: Comfort Care
Care whose intent is to relieve suffering and provide for the patient’s comfort and dignity. It may include analgesics, narcotics, tranquilizers, local nursing measures, and other treatments including psychological and spiritual counseling. It should be emphasized that although a particular treatment may be futile, palliative or comfort care is never futile.
Medical Ethics and the Law

- Act according to defined hospital futility policy. Do not ask courts for permission to withdraw futile or unwanted treatment. The courts will (and should) refuse. Act ethically and be prepared to defend if necessary. The courts will (and have agreed).
Is there a standard of practice regarding medical futility?

Majority standard:
• Medical futility refers to treatments that offer no realistic quantitative or qualitative benefit to the patient.
• If this is your standard, document it in your institutional policy and provide procedures for compassionate dispute resolution and effective comfort care.
• Declare this policy as your professional standard of practice for the information of the public and as a guideline to the courts.

Respectable minority standard:
• Alternative definition or no documented limit on life-sustaining treatment.
• Declare this policy as your professional standard of practice for the information of the public and as a guideline to the courts.
• Accept transferred patient and avoid court dispute and emotional distress.
Court Order to Treat Baby Prompts a Debate on Ethics

By LINDA GREENHOUSE

WASHINGTON, Feb. 19 — A recent Federal appeals court ruling that a Virginia hospital must provide life-sustaining treatment for a baby born missing most of her brain has alarmed hospital administrators and specialists in medical ethics. They say there is little hope for holding down health care costs if family members have a legal right to insist on treatments that doc-

At what point does treatment cease to be worth the expense?