Futility-caveat lector

Graham R. Howarth, MBChB, MMed(OetG), MPhil(Bioethics)
Medico-legal advisor for the Medical Protection Society
Leeds, UK.

In some ways, those persons who practice medicine have become victims of its success. We wish to do the best for our patients. However, occasionally the advantages of treatment may be marginal. Added to this is the spiraling cost of medical therapy, something that doctors are aware of. To make the problem even more difficult we have increasing awareness by patients and their families of the concepts of autonomy and patient's rights. They feel that they can demand treatment that the doctor may feel is of no or marginal benefit; possibly also at great expense. This may be one treatment that the doctor is reluctant to sanction. Futility has been advanced as a type of moral trump card in these situations, that can usurp patient autonomy, in the sense that we do not have to give treatment that we consider to be futile, despite the patient requesting the treatment. *(SA Fam Pract 2003;45(8):48-49)*

"Futility" is by no means a new concept. The word is etymologically derived from "*futilis*", the Latin meaning leaky. Greek mythology well describes the concept of futility in the legend of the Danaides. The legend has it that 49 of the 50 daughters of Danaus, King of Argos, killed their husbands on their communal wedding night, on instruction from their father. As a result they were condemned to Hades for eternity, where they had to carry water to fill a vase. They were condemned to carry the water to the vase using sieves. To arrive at a destination, in this case the vase, with no water gives one an idea of the concept of futility – basically, doing something that is useless or ineffective.

Without adequate reflection using futility to justify withholding or withdrawing "useless" treatment is meretricious. It appears so obvious; we should not treat where we consider that the treatment is "useless". We may even feel justified in going one step further, and directly challenge patient autonomy: if we consider treatment to be futile, we may even be able to justify declining the treatment, despite the patient's request!

The argument appears to gather momentum when we begin to consider the financial constraints on contemporary medicine. Futility, where treatment is deemed to be useless, must be clearly distinguished from rationing. In rationing we acknowledge that there may be benefit, but if treatment is to be denied or withdrawn, this is due to questions of cost. Futility implies no effect and takes no cognisance of cost issues. Futility addresses outcome or at least the lack thereof, and financial implications play no role; rationing on the other hand acknowledges benefit, but takes cognisance of costs. Indeed if we decide to withhold or withdraw treatment based on the rationing of that treatment, financial considerations, by definition, will have played a major role in the decision-making process. Invoking futility to justify non-treatment or withdrawal of care is probably more psychologically appealing, as it appears to be a more moral justification, than accepting financial constraints and acknowledging rationing as the justification.

So, what is the problem with utilising futility to withhold, withdraw or refuse treatment? One of the major criticisms is that futility is a complex term with both quantitative and qualitative elements. Quantitatively, how seldom must the outcome occur that we are seeking before we can say that an intervention is useless or futile? Never, or below an arbitrarily defined threshold? A threshold below 1 in 100 has been suggested, however this is obviously open to criticism, why 1 in 100? Why not 1 in 1000? If you required a life saving procedure, with minimal or no side effects, and there was only a 1 in a 100 chance of success, would you be happy to turn it down as it would be futile? Even if we were to accept this arbitrary threshold of 1 in 100, on what would we base the probability of the outcome? Doctors seldom have the experience, or can't remember the outcome in the previous 100 similar cases. In addition, each case is unique, and it is difficult, indeed impossible to extrapolate the potential outcome of a single complex based on your recollection of similar but equally unique previous cases. Due to the nuances of individual cases, referring to the literature is equally unaccommodating.

The qualitative element is probably even more contentious. Judgements of futility only make sense in relation to a

qualitative outcome, a specific goal; what type of outcome or goal are we attempting to achieve?

To explain the qualitative and quantitative element, let me make use of the lottery as an analogy. If you buy a lottery ticket to win the jackpot (the outcome or qualitative element) then your chances (the quantitative element) are extremely low. If on the other hand you buy lottery tickets to give money to charity (the qualitative element) then your chances are extremely high (the qualitative element).

Ideally we need to describe the outcomes in terms of value-free descriptions that we could all agree upon. To facilitate our understanding of outcomes, Brody has described four qualitative categories for outcome objectives. The least contentious is the physiological objective, for example when cardiopulmonary resuscitation produces no pulse. Here the goal would be merely to achieve a physiological objective, (a pulse) following a cardiopulmonary resuscitation attempt in response to a cardiac arrest. If you were sure that you would not be successful in achieving a pulse, then you classify the intervention as being futile. The second category is where the intervention may achieve its physiological objective, but with consequences that the patient would consider unacceptable. In the third category, the physiological outcome may be achieved, but with consequences which the vast majority of people would find unacceptable. The final and fourth category is where the intervention may achieve its physiological objective, however the burdens of intervention far outweigh the benefits in the opinion of the doctor; even if this is in conflict with the patient's opinion. As we can see, unfortunately none of these outcomes are entirely value free. However, if we take cognisance of respect for patient autonomy, the second category is the most morally appealing, whilst the fourth is extremely paternalistic.

Caveat lector – let the reader beware; if you wish to withhold, withdraw or refuse treatment, and use futility to justify your decision, beware! Beware that the concept of futility, in the medical context, is by no means simple. It has both complex and unpredictable quantitative and quantitative elements that are not value-free.❐

Please refer to the CPD Questionnaire on page 51.

Sources and further reading:

1. Gillon R. "Futility" – too ambiguous and pejorative a term? *Journal of Medical Ethics* 1997;23:339-340.
2. Ardagh M. Futility has no utility in resuscitation medicine. *Journal of Medical Ethics* 2000:26:396-399.
3. Weijer C, Elliott C. Pulling the plug on futility. *BMJ* 1995;310:683-684.
4. Schneiderman LJ, Jecker N. Futility in Practice. Arch Intern Med 1993;153:437-441.

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