Ethical Issues in Family Practice:

Medical Futility – The debate

Knapp van Bogaert D
Part-time senior lecturer
Biomedical Ethics – Dept. of Family Medicine &
Primary Health Care, Medunsa and SARETI*

Ogunbanjo GA
Dept. of Family Medicine & Primary Health Care,
Medical University of Southern Africa (Medunsa), Pretoria

Keywords: ethical, medical futility, debate, litigation

(SA Fam Pract 2004;46(1): 35-36)

Like most ethical and bioethical dilemmas, the 'futility debate' has a long history. Both Hippocrates and Plato mentioned the problem. The *Corpus Hippocraticum* states: "Whenever a man suffers from an ill which is too strong for the means at the disposal of medicine, he surely must not even expect that it be overcome by medicine". In *The Republic*, Plato writes: "For those whose bodies were always in a state of inner sickness Asclepios did not attempt to prescribe a regimen to make their life a prolonged misery". In fact, it was not until the early 1990s that the concept of medical futility became widely discussed. This is attributable to the advances in medical technology. Because of the lack of agreement on what it means or what implications it conveys, ethicists like Paris & Schreiber have concluded that the debate is "fatuous, a modern-day relapse into nominalism".[1] They recommended focusing our attention on the moral basis of the participants' actions and decisions rather on the meaning of the word. Nevertheless, a definition is in order for a meaningful debate to take place. A fair working-definition would see futility as *"an ethical dispute about whether a medical team could be forced by a family member to continue care it regards as futile"*.[2] Also it could be defined as *"a care that is not likely to produce the wanted effect"*.[3]

On the one hand, the refusal by health professional(s) is motivated by two reasons, that is, the requested care is unlikely to benefit the patient, and the cost or scarcity of the treatment does not justify its use in the case under consideration.[4] On the other hand, the request for that treatment emanates from the patient or from his or her surrogate, if in an incompetent state. The futility debate results from a divergence between the attitudes of the patient or of his or her surrogates and health-care workers towards the care of the patient.[5] On the latter side, the two main questions are: What is the likelihood that the treatment would fail, and what is its wanted effect if it were administered? The probability of failure that would justify the refusal varies from 100 to 82%; most physicians, however, would seem to settle for a failure rate between 95 and 99%.[6] The wanted effect if the treatment were to be administered varies from the prevention of death or at least of very serious compromise, to full recovery of normal functioning (ibid.).

In a section of their publication titled "Reframing the Debate", Paris & Schreiber displace the ethical debate away from the patient to the decision-maker.[1] They pose two commonly asked questions:

- Is there a limit to the physician's obligation to honour a patient's

demand for treatment?
- Must the physician, if asked, always employ whatever is required to preserve life?

The answer, they argue, is not *whether* but *which* value judgement health professionals may use in determining whether to follow the patients' or their surrogates' demands. The *whether* question has been addressed showing a wide range of probabilities and expectations to justify or reject the care. To answer the question of *which* value judgements should be used requires, according to Paris & Schreiber, guidance to be looked for in the common social senses of the approved practices that are to prevail.[1] And this approval, they recommend, should be obtained through the consensus expressed by the health professionals team and the institutional ethics committee, and should be open to a second opinion.

The 'futility debate' is thus not as fatuous as it has been claimed, certainly not in developing world settings where priorities rank differently. In developed countries, it happens that, through the advocacy by bioethicists and families' wishes, patients in a permanent vegetative state are maintained alive with total parenteral nutrition despite the certainty that the condition is hopeless and irreversible. [2] Likewise, anencephalic newborns are put on a ventilator. This is done out of a belief that even unconscious life should be protected and preserved at all cost, or out of fear of medico-legal litigation. [5]

In South Africa, however, although clinical ethical dilemmas are of a different nature they are no easier to address. This is especially true with the limited resources available in the public health sector. Let us look at some examples. End of life decisions in ICU, a typical example of medical futility in the developed world, would in many instances not create a futility dilemma. But what about total parenteral nutrition of a patient with advanced incurable oesophageal cancer? Is it justified to spend meager resources that would deprive other salvageable patients of treatment? Is it futile? Or, a woman who had a bilateral tubal ligation and her husband dies; she remarries. If she does not bear children for her new husband, he may decide to divorce her. Should we proceed with the requested tubal reanastomosis to ensure her status in the society? Or is this medical futility? It should be clear by now that there is deep disagreement concerning the definitions of 'futility' and that the perceptions about the concept are deeply contextualised. Is a liver transplant of an alcoholic patient futile because of the likelihood of recidivism? Who knows how likely recidivism is? If a specific treatment of a specific patient has no chance of success whatsoever, it would be futile to administer it. But if the chance is up to 18%, is it still futile? Would it be futile to keep someone alive in ICU to grant the opportunity to say goodbye or to finalise some family matters?

Disagreement in a debate is not enough to call it fatuous. The difficulty is: *Who makes the decision and on what acceptable grounds?* It should certainly not be the attending physician in isolation. Even in the absence of an institutional ethics board, as it is the case in most state run facilities, advice can be sought from the health professional team. In addition, in the context of scarcity, the principles of *distributive justice* should be borne in mind. Food for thought!

See CPD Questionnaire, Page 47

References

1. Paris JJ, Schreiber MD. Physicians' refusal to provide life-prolonging medical interventions. *Clinics in Perinatology* 1996; 23: 563-572.
2. Pence G. *Classic Cases in Medical Ethics*. 2nd ed. New York: McGraw-Hill
3. Brock D. Medical decisions at the end of life. In: H. Kuhse & P. Singer (Eds.), *A Companion to Bioethics*. Oxford: Blackwell, 1998: 231- 241.
4. Capron AM. Advance Directives. In: H. Kuhse & P. Singer (Eds.). *A Companion to Bioethics*. Oxford: Blackwell, 1998: 261- 271.
5. Elliott C. Patients doubtfully capable or incapable of consent. In: H. Kuhse & P. Singer (Eds.), *A Companion to Bioethics*. Oxford: Blackwell, 1998: 452-462.
6. Sexson WR, Overall SW. Ethical decision making in perinatal asphyxia. *Clinics in Perinatology* 1996; 23: 509-518.

* *SARETI is the South African Research Ethics Initiative a Fogarty / NIH academic degree programme in research ethics at the University of Pretoria and the University of Natal.*