



THE CONCEPT OF FUTILITY

Patients Do Not Have a Right to Demand Medically Useless Treatment

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I will use the diata [treatment] to help the sick according to my ability and judgement, but never with a view to injury and wrong-doing.

—From the Hippocratic Oath

The norm of beneficence, which directs physicians to apply their insights and techniques for patients' good, has been a basic principle of medical ethics for 2,500 years.

Under this principle, physicians do not provide treatments when the interventions at their disposal do not produce medical benefits.

Traditionally, when medical treatment was provided in a paternalistic style (i.e., when physicians made treatment choices without asking their patients' permission), the application of the norm of beneficence was relatively straightforward. Today, however, an ethic of patient autonomy and informed consent has replaced the traditional paternalistic approach that gave maximum

authority (as well as responsibility) to the physician. Thus the principle of beneficence must now be balanced with the principle of patient self-determination.

The question we address here is whether the patient self-determination requirement can compel physicians to make futile interventions—treatments they know provide no benefits and therefore violate the beneficence principle. The futility issue can be a key ethical consideration in cases in which the principles of physician beneficence and patient autonomy appear to conflict.

PHYSICIAN BENEFICENCE AND PATIENT AUTONOMY

Patient autonomy, or self-determination, is first a right to refuse treatment and then a right to choose from among medically justifiable options. It is *not* a right to demand treatment. Put differently, a patient's right to choose or refuse treatment is limited by the physician's right (and duty) to practice medicine responsibly. The belief that medical professionals ought to respect the

Summary Traditionally, applying the principle that physicians do not provide treatments when the interventions at their disposal do not produce medical benefits has been relatively straightforward. However, with the growing importance of patient autonomy and informed consent in treatment decisions, ethicists must now balance this principle with the principle of patient self-determination.

A patient's right to choose or refuse treatment is limited by the physician's right (and duty) to practice medicine responsibly. Bizarre or destructive choices made by a patient are not sacrosanct simply because the patient made them. In some cases, physicians may choose not to act on patient decisions that appear to be unreasonably destructive.

Physicians also have a right to refuse to provide futile treatments (i.e., interventions that might be physiologically effective in some sense but cannot benefit a patient). Patients themselves have a right to provide input into what would constitute a "benefit" for them, but physicians should be able to decide when a particular treatment is futile based on their knowledge of the treatment's effects and its likely impact on a patient's quality of life.

Ethical rules covering futility can be developed based on socially sanctioned standards of rationality and traditional physician-based values. Clarifying the concept of futility and establishing defensible ethical policies covering futility are important steps toward eliminating unhelpful, medically inappropriate practices.

informed choices of patients or their surrogates arises, first, out of respect for autonomy. But it is also a consequence of the realization that beneficence is ordinarily best served when patients can judge for themselves the impact of various treatment options on their life plans and personal goals.

Although patients ordinarily choose a course of action they judge to be in their best interests, sometimes they make bizarre and destructive choices. Such irrational choices are not sacrosanct simply because the patient made them. Commitment to beneficence demands at least that physicians try to understand patients' intent and motivation and to influence them to make a rational decision. In some cases, physicians may choose not to act on patient decisions that appear to be unreasonably destructive.¹

Professional discretion and judgment are always part of the clinical decision-making process. Physicians should communicate with patients throughout the treatment process and must monitor patient participation in medical decision making. Physicians, in effect, make judgments about the nature and relevance of patient values, in addition to making value judgments about medical issues. They evaluate patient competency based on patients' responses to medical interventions, their thoughts about their medical situations, and their reasons for deciding one way or the other.

To suggest that doctors abandon all such judgments and then ignore the personal harm resulting from a risky or useless intervention "because the patient asked for it" is to subvert the core of medical professionalism.² Medical judgments are never value free. However, physicians should be aware of the value components of their decisions and be able to justify them.³

Value commitments (e.g., relieve suffering, do not assist in suicide, do not harm patients, do not cause suffering without proportionate benefit) inform most physician decisions. These professional standards reflect medical values and guide judgments about the appropriateness of a medical intervention for a particular patient. Among these



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standards should be the following: Do not offer futile treatments as medical options.⁴

THE CONCEPT OF FUTILITY

The concept of futility has had historic importance in medicine. For Hippocratic physicians, attempting a futile treatment was a display of ignorance.⁵ Contemporary ethical standards published by the Council on Ethical and Judicial Affairs of the American Medical Association (AMA) show continuity with this tradition: "Physicians should not provide or

seek compensation for services that are known to be unnecessary or worthless."⁶

Because the concept of futility has been consistently confused with other concepts and categories, some distinctions are in order. A futile intervention is different from one that is *harmful* (e.g., poison), *ineffective* (like cough drops for a lymphoma), or *impossible* (like a self-administered coronary bypass). Nor is a futile intervention the same as a treatment whose goal is to achieve *uncommon* or *unusual* outcomes, like the long-term survival of a patient with metastatic pancreatic cancer. The issue of whether a situation is deemed *hopeless* is also irrelevant to the issue of futility, since hope is a subjective disposition that can be maintained even in the face of impossible situations. Finally, while certain treatments in certain situations are simply too expensive for a family or a society, it does not help to refer to these as economically futile.⁷ Much of the confusion about futility arises when authors claim to be talking about this concept but are actually addressing very different issues.

Some clarity can be achieved by distinguishing futility from ineffectiveness. In contemporary medicine, ineffectiveness is determined statistically on the basis of accepted scientific standards. A 0 percent success rate in 1,000 trials, for example, would constitute an ineffective treatment. Categorizing a treatment as ineffective, however, does not imply 100 percent certainty about its outcome, because the next trial might reveal an effect not evident in the previous 1,000. Another closely related category is *highly improbable*. In this case, a given treatment may have been successful on a few occasions, but its success can nei-



ther be scientifically explained nor reliably predicted.

A futile treatment differs from an ineffective or highly improbable treatment in that it is always somewhat effective (e.g., a temperature is lowered or raised, lung function is sustained). However, futile treatments are fruitless because they do not achieve "worth" in the sense of meeting a patient's medical goal or providing a true personal benefit.⁸ Doctor-patient communication is sometimes required to know that personal patient benefit cannot be attained, but at other times it is obvious (with the permanently unconscious or dying).

In light of the above distinctions, a medically futile treatment can be more accurately defined as an action, intervention, or procedure that might be physiologically effective in a given case, but cannot benefit the patient, no matter how often it is repeated. A futile treatment is not ineffective, but it is worthless, either because the medical action itself is futile (no matter what the patient's condition) or the condition of the patient makes it futile.⁹

FUTILITY AND PATIENT CONSENT

Attempts to determine personal patient benefit or acceptable quality of life ordinarily depend on

patient input. Should all futility questions then be left up to patients or surrogates? Do futility decisions fall outside physician discretion?

Some medical ethicists think so.¹⁰ We take the opposite position. Determining futility entails evaluations of a medical intervention and a patient's medical status that only a physician can make. Physicians know, for example, that cardiopulmonary resuscitation (CPR) can do no good for terminal patients whose cardiac arrest relates to the natural progression of their disease.¹¹ Even if the patient is incompetent and no family is available to provide input about his or her preferences, physicians in consultation with other team members can decide that a particular treatment cannot achieve medical goals, values, or objectives.

The discussion of futile treatments with patients and family is altogether appropriate,¹² except when such a discussion would cause added and unbearable burden to an already difficult situation. The objective of such discussions is to help patients and families understand the clinical situation and why a particular intervention is not an option. The physician should be as responsive as possible to the patient's physical, emotional, and spiritual needs, but neither consent nor refusal should be requested.

The AMA's Council on Ethical and Judicial Affairs upheld this view in deciding that physicians need not seek consent for a do-not-resuscitate order when CPR is deemed futile.¹³ Informed consent is a process by which competent patients make judgments about real options and, as such, supposes socially sanctioned standards of rationality. Although some individuals may operate outside these rational limits (e.g., by demanding what is useless or futile), they cannot insist that professional standards and public policies support their preferences.

Benevolence requires that doctors do only what is medically helpful. Individual autonomy cannot be so inflated in importance as to destroy the principle of beneficence. The key to the futility debate is identifying what constitutes legitimate medical help. Like most contemporary medical ethics problems, determining futility requires balancing the values and goals of medicine with the goals and values of patients, taking into consideration the uncertainty inherent in making predictive medical judgments.¹⁴ Inevitably there will be some differences among physicians in judging uncertainty and the helpfulness of specific treatments.¹⁵

ETHICAL RULES, RATIONALITY, AND BENEVOLENCE

Ethical rules covering futility can be developed based on socially sanctioned standards of rational-

ETHICAL GUIDELINES FOR DETERMINING FUTILITY

- A treatment is futile and the physician should not present it to a patient or surrogate as an option when, for example, the treatment:

1. Does not alter a person's persistent vegetative state
2. Does not alter diseases or defects that make a baby's survival beyond infancy impossible
3. Leaves permanently unrestored a patient's neurocardiorespiratory capacity, capacity for relationship, or moral agency
4. Will not help free a patient from permanent dependency on total intensive care support

- Because they require assessment of medical interventions and their relation to medical goals, decisions about futility are made by physicians, even though they involve considerations of patient benefit or patient quality of life. Some quality-of-life judgments are linked with traditional medical goals and values and assume public standards of rationality.

- Because medicine is directed to patient benefit, not everything a doctor can do falls within the ethical goals of medicine.

- Futility always involves a failure to achieve a medical goal or a personal good. If patients do not benefit in a medical sense, even temporarily effective treatments are futile and physicians have a right (indeed a duty) based on the principles of beneficence and nonmaleficence not to offer them.

ity and on traditional physician-based values. Several such rules are suggested in the **Box**.

Some ethicists argue that allowing physicians to not offer futile treatment to patients would constitute an unacceptable return to paternalistic medical practice. They hold, in effect, that physician assessments of benefit are always suspect, and that benefit is so inherently subjective that even the most idiosyncratic patient or surrogate choices must be honored.

Obviously, a physician's decision will reflect his or her values. A professional physician's value judgment, however, will be neither random nor individualistic. If doubt is raised about an instance of physician decision making, the decision can be reviewed by an ethics committee to make sure that beneficence and not some selfish value is operating.

An extreme autonomy position ignores the fact that a well-established "best interest" standard assumes both a connectedness of the patient to family and physician and a communication process that allows surrogates to decide based on objective, community-based best interest standards.¹⁶ The existence of such standards and their relevance to medical decision making can be seen from the fact that five state courts recently permitted forgoing life supports for incompetent patients who had never expressed a previous preference.¹⁷ Without available subjective preference, the decisions were made on physicians' and families' objective evaluations of a patient's best interest.

The current situation, in which patients or their surrogates are commonly (but falsely) led to believe that futile treatments are medically acceptable, actually does violence to the principle of autonomy, as well as to beneficence. It creates a sphere of decision making where (rationally) none exists and, thus, seems intrinsically deceptive.

Frequently, physicians believe they have done their duty when they allow patients or families to make difficult treatment decisions, even when they have not explained sufficiently the medical and human consequences of the options. In such cases the focus on patient choice diminishes the



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physician's commitment to professional duty and patient well-being. Thus we believe that respect for autonomy and beneficence is impaired by allowing patients to choose futile treatments or by claiming that the concept of futility is so inherently subjective that it is useless.

Weakening futility as a workable category has other ill effects. Aggressive treatments that override considerations of futility are frequently justified by standards requiring absolute certainty and

by fear of malpractice. Clarifying the concept of futility and establishing defensible ethical policies covering futility are important steps toward eliminating unhelpful, medically inappropriate practices. Even the famous Baby Doe regulations of the Reagan administration, which advocated aggressive medical interventions for infants in almost all situations, recognized an exception for futility and virtual futility, when medical goals could not be achieved and quality of life had slipped below what is considered acceptably human.¹⁸

THE HELGA WANGLIE CASE

The Helga Wanglie case did for the futility issue what the Nancy Cruzan case did for the question of medical alimentation.¹⁹ Wanglie, an 85-year-old nursing home resident, was transferred to a hospital after suffering a heart attack. She had been resuscitated but remained unconscious and on a respirator. Physicians at that hospital considered continued technological life-sustaining support to be futile and wanted to withdraw it. Wanglie's husband refused and had her transferred to another medical center, where she was diagnosed as being in a persistent vegetative state. Again doctors recommended withdrawal of the ventilator because no medical goals for the patient could be realized.

The family thought the suggestion of withdrawal of life-sustaining technologies reflected moral decay in our culture and hoped instead for a miracle. Ultimately, the hospital went to court to ask whether medical professionals were obliged to provide what they considered to be unbeneficial and inappropriate treatment. The husband (a



lawyer) then crossfiled, asking that he be appointed conservator. The court decided in favor of the husband's petition. More than a year after the initial hospitalization, and three days after the court decision in favor of Mr. Wanglie, Helga Wanglie died of multisystem organ failure and septicemia.

Once the Helga Wanglie case was taken to court, we could have expected that the values of the courts would inform its judgment. The judge did not address the issue of medical values or physician discretion in medical practice. Rather, he ruled that the husband was the proper surrogate and that the surrogate's claims about the patient wishes were reliable. In a culture ruled by individual rights and a purely subjective view of autonomy, the surrogate's freedom to decide about treatment held priority over physician or professional judgment about the treatment's futility.

If Helga Wanglie had actually wanted her treatment, it could be argued that she was getting some "benefit" from continuing it in the face of futility. (There is good reason to believe she did not want it.) But this kind of "benefit" is not what is meant by benefit in the history of medical ethics. Personal medical benefit consists of such advantages as restoration of health, cure, pain relief, comfort, alleviation of suffering, and improved well-being or quality of life. The principle of beneficence calls on physicians to help patients achieve those particular goals, not just any goals or any interests.

FOR TRADITIONAL STANDARDS

Futility and physician discretion arguments will increasingly be crowded out by another influence on physician discretion—cost. The need to control medical costs will require that strict statistical measures of effectiveness be used to limit the options physicians can offer.

But independent of limitations on treatment options that might be imposed by considerations of justice and public policy, we have shown that an analysis based on beneficence allows physicians to refuse to offer—in fact, makes it their duty *not* to offer—futile or ineffective treatments. Futile and ineffective treatments are not acceptable or advisable even if they can be afforded.

The idea that a right exists to futile treatments is absurd, especially when there is not enough money for basic care for millions. Physicians and health-care institutions need to make a stand for traditional medical rights and professional standards. □

NOTES

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