Futility

King et al. “Task Force 2: Application of Medical and Surgical Interventions Near the End of Life.” *JACC* 1998; 31(5): 917-49. (from the ACC website guidelines)

Key Points:
- **Futility, quantitative and qualitative, is a difficult concept to define**
- **Physicians cite futility when other factors (best interests, distributive justice) are more central in their minds**
- **Open discussions with patients and surrogates, rather than unilateral decisions, are critical**

Background
- Concept introduced in 1987
- Courts do not find in favor of unilateral decisions by physicians
  - Notable exception: *Gilgunn v. Massachusetts General Hospital* (DNR order placed by physicians, lawsuit filed after death, jury decision with official record of reasons)

When is an intervention futile in a strict sense?
- Intervention has no pathophysiologic rationale
- Cardiac arrest occurs despite maximal treatment
- Intervention has already failed in the patient

Loose definitions and confounding issues
- Likelihood of success is very small
  - Quantitative probabilistic concept of 1% often cited (Schneiderman et al 1990)
  - Applies to few patients: in SUPPORT 0.02% of all hospitalized patients had <1% prospect of surviving >1 week
  - Threshold when physicians studied have been as high as 20%
  - Lack of reliable outcomes data for many interventions
- No worthwhile goals of care can be achieved
  - Physicians vs. patient / family defined goals of care
- Quality of life is unacceptable
  - In one study, assessment of QOL only discussed with patient 65% of the time
- Prospective benefit is not worth the resources required
  - Rationing as a separate debate on distributive justice
  - Societal vs. individual level of judgment
- Best interests vs. futility
  - Physicians not obligated to provide interventions they believe are not in the patient’s best interests, but physicians should note cite futility as the reason for their decisions
- Unilateral decisions by physicians and issues of autonomy
  - Can be perceived as antagonistic by patients and surrogates
  - Can disguise assumptions and value judgments as scientific data
- Ageism
  - Elderly (>75) less often studied – less data on risks and benefits of interventions
  - Both potential benefits and risks may increase with age
  - More often subjected to arguments of distributive justice
- Why worry when everyone agrees?
  - Concept of futility less often challenged or discussed when their congruence in decision-making between physician and patient / surrogate (as with consent)

Safeguards and guidelines
- Establish explicit guidelines of futility, defining not only terms but processes for communication
  - Guidelines for the Use of Intensive Care in Denver and Houston Citywide Policy on Medical Futility
- Obtain a second opinion
- Discuss the intervention with the patient or surrogate
- “Treatment” vs. “care”: “A specific treatment may be futile; care (especially palliative care) is never futile.” (ACC guidelines)