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Medical Futility
A New Look at an Old Problem

Cheryl J. Misak, DPhil; Douglas B. White, MD; and Robert D. Truog, MD

Efforts to answer the question of whether or when physicians may unilaterally refuse to provide treatments they deem medically futile, but that are nonetheless demanded by patients or their surrogates, have been characterized as intractable failures. We propose a new look at this old problem and suggest reframing the debate in terms of the implicit social contract, in healthy democracies, between the medical profession and the society it serves. This ever-evolving contract is predicated upon providing patients with beneficial and desired medical care within the constraints of scarce resources and the characteristics of our health-care system. The contract ranges over a continuum of decisions, from those that do not need an explicit negotiated agreement with the patient or surrogate, to those that do. Between these two poles lies a contentious gray area, where the rights and obligations of patients and physicians are being shaped continuously by the many forces that are at play in a democratic society, including professional guidelines, social advocacy, legislation, and litigation. We provide examples of how this gray area has been and is negotiated around rights to refuse and demand a variety of life-sustaining treatments, and anticipate conflicts likely to arise in the future. Reframing the futility debate in this way reveals that the issue is not a story of intractable failure, but rather, a successful narrative about how democracies balance the legitimate perspectives of patients and physicians against a backdrop of societal constraints and values.

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ABBREVIATIONS: ECLS = extracorporeal life support

We are in the midst of a decades-long debate about medical futility, specifically about the question of when physicians can overrule demands by patients and surrogates for treatments the physicians believe to be futile or inappropriate.[1-3] Initial approaches focused on defining futility in terms of medical diagnoses, probability of success, or quality of outcome.[4,5] These proved contentious.[6] In 1999, the American Medical Association endorsed a procedural approach, in which futility is an "all things considered" type of judgment that must be made on a case-by-case basis, balancing the conflicting values of patients and clinicians.[7] Today, many hospitals have procedural policies, and Texas offers civil and criminal immunity to physicians who follow legislated

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AFFILIATIONS: From the Department of Philosophy (Dr Misak), University of Toronto, Toronto, ON, Canada; Program on Ethics and Decision Making in Critical Illness (Dr White), Department of Critical Care Medicine, University of Pittsburgh School of Medicine, Pittsburgh, PA; the Division of Critical Care Medicine (Dr Truog), Department of Anesthesia, Perioperative and Pain Medicine, Boston Children's Hospital, Boston, MA; and the Center for Bioethics (Dr Truog), Harvard Medical School, Boston, MA.

CORRESPONDENCE TO: Robert D. Truog, MD, Boston Children's Hospital / Bader 621, 300 Longwood Ave, Boston, MA 02115; e-mail: robert.truog@childrens.harvard.edu

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rules.[8] Yet there continue to be concerns that these approaches can be unfair, giving too much power and control to physicians and hospitals.[9]

Efforts to answer the question of whether or when physicians may unilaterally refuse to provide treatments they deem medically futile, but that are nonetheless demanded by patients or their surrogates, have been characterized as intractable failures.[6] We aim to shift the discussion. Rather than seeing the problem of futility as a succession of failed attempts to solve a problem that still awaits its definitive answer, we suggest that the proffered solutions to the problem of futility should be seen, in aggregate, as an example of how complex and difficult matters are best dealt with in a democratic society. The futility debate is an ever-fluid dialogue involving the medical profession and society. Futility policies or laws do not offer permanent or absolute solutions, but rather, they are part of the continual redefining of the boundaries of decision-making authority between physicians and patients, involving a variety of professional, cultural, religious, civic, and legal values and mechanisms. In short, we argue that disputes around medical futility are not problems in search of a clear-cut solution, but rather, dynamic problems that are always being addressed in the ways characteristic of a liberal democracy. This reframing has the significant benefit of seeing futility debates as being responsive to new arguments and articulations of what it is that we value and as gravitating toward better answers to the profound problems that press in on us about the end of life.[10,11]

Reframing the Question

Throughout the history of the futility debate, the question has been put in terms of whether or when physicians may act unilaterally, either by choosing not to offer certain treatments, or by explicitly rejecting treatments requested by the patient or surrogate. Our suggestion is that this is an unhelpful and myopic lens through which to view futility. Medical decisions are never made unilaterally, even though at times this may appear to be the case. Medical decisions are made in the context of an implicit and evolving social contract among patients, physicians, and societies at large. Within this implicit contract, we argue, many legitimate medical decisions do not require physicians to explicitly negotiate an agreement with the patient or family, whereas other types of medical decisions do require an explicit negotiation that involves discussion of feasible medical options, risks and benefits, and the values and preferences of the patient. Between these two poles there is a sometimes contentious gray area. By reframing the futility debate as a debate within society, we shift the question away from unilateral decision-making and procedural approaches to one of balancing the legitimate perspectives of patients and physicians against a backdrop of societal constraints and values. In what follows, we present the kinds of cases and vignettes that illustrate them.

The Relatively Straightforward Cases

In many cases, the connection between the goals of the patient and the appropriate treatment are clear and form part of our background assumptions. The goals of an otherwise healthy postsurgical patient are best served by checking vital signs at regular intervals postoperatively; those of an otherwise healthy child with bacterial meningitis are best served by antibiotics; those of a young man with sudden cardiac arrest are best served by CPR. Similarly, we refrain from treatment when there is no medical or scientific reason to believe that the treatment would be effective or beneficial, as when we withhold CPR from a patient in rigor mortis. Here, clinicians initiate or abstain from treatments without being required to first negotiate with and gain consent from patients or their surrogates. This does not mean that the duties to inform, discuss, and communicate with patients and their families fall by the wayside. It is important not to confuse the need to negotiate with the need to communicate.

In these straightforward unnegotiated cases, the reasons to act, or to refrain from action, are clear. Sometimes there is a rule or a law in place; for example, we might give life-saving treatment to children, under laws prohibiting child neglect, even if their parents refuse. Sometimes, for instance as with emergency treatment, there is a set of widely accepted norms of practice that allow clinicians to initiate treatment without consent. In other cases, clinicians have professional expertise that patients and their surrogates lack, and norms of good practice from which patients want to benefit. And in ICUs, where decisions must often be made on very short notice, care would grind to a halt if moment-to-moment decisions (eg, which pressor or antibiotic to initiate) could not be taken by those charged with caring for patients.

But even when clinicians are making decisions in some sense on their own, it would be a mistake to call them unilateral. Under the implicit terms of the social contract, it has been agreed that physicians should make these judgments. They are made not in isolated arrogance,