Medical Futility: The Ethical Dilemma

Abstract

- Ordinary meanings of futile include: ineffective, useless, unsuccessful, and meritless
- A medical act is considered futile if the desired outcome (achieving the goals of medicine) is overwhelmingly improbable:
  a. Quantitative futility assessment: Numerical probability that medical intervention will produce a desired physiological effect.
  b. Qualitative: Probability that the attained physiological effect will benefit the patient.
     i. Requires judgment of the quality of treatment outcome, so it is inescapably subjective (Bernat).
- Overall futility, is a product of these two assessments; thus, determination of medical futility can be made with a very low probability of either assessment.
- "Futile" refers to a specific medical intervention applied to a unique patient at a particular time - a patient-centered definition of medical futility (Jecker).
- Extremely complex, ambiguous, subjective, situation specific, value-driven, and goal-dependent concept which is almost always surrounded by uncertainty (Aghabarary).

WHAT IS MEDICAL FUTILITY?

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WHY TALK ABOUT MEDICAL FUTILITY?

1. There is a growing elderly population that will need end-of-life care and it is necessary to have ethically competent physicians that can effectively work with families to maintain patient autonomy once their treatment options become futile.
2. There is a lack of resources and medical futility may take up resources other patients may need, cost may be unsustainable (Ruth).
3. End-of-life care and medical futility are taught or discussed minimally within the realm of medicine (discomfort or inexperience with death and dying).
4. Advancement of medical technology may lead to inappropriate end-of-life care.
5. The law behind medical futility is fragmented and there is a lack of a framework.

FUTILITY

- A futile action is linked to a goal – if the goal is unattainable, the act is futile.

Potential Guidelines to Minimize Conflict and Negotiate Treatment

1. Keep patients and families informed.
2. identify other staff members to facilitate good patient relations.
3. Promote realistic expectations.
4. Provide accurate prognosis.
5. Maintain continuity of care.
6. Be compassionate and flexible.
7. Show firmness about limits
8. Beware of making decisions based on economic market forces (Bernat).

Guidelines to Settle a Dispute

1. Transfer patients to care of another physician if values conflict
2. involve consultants if disagreements about data arise
3. Involve hospital ethics committee
4. Attempt to transfer patient to another hospital
5. Only if this fails, physicians can cease futile intervention (Bernat)

Case Study - Jahi McMath

- Jahi McMath, a 13-year-old girl, was declared brain dead in California after a hemorrhagic complication following a surgical procedure removing her tonsils, adenoids, and extra sinus tissue.
- Her parents wanted to continue life support, contending she showed signs of life. However, the doctors declined, considering it to be a futile treatment of a deceased person, declaring her brain dead.
- Biologically alive in an apartment in New Jersey, supported by a ventilator, tube feedings, and supplemental hormones
- Continued to grow and progress through puberty
- Jahi McMath "officially" died in 2018
- This issue displays the great complexity of medical futility and how difficult it can be to come to a consensus. The parents are not at fault for having hope, but neither are the physicians (Luce).

ETHICAL ISSUES

1. **Physician vs. Patient/Family:** The physician's medical expertise on the case should/should not outweigh the wishes of the family of the patient.
2. **Subjectivity:** Criteria that allow decision-makers to choose if a treatment is considered to be futile or not is subjective (Aghabarary).
3. **Rationing vs. Autonomy:** Medical resources being rationed when a patient is approaching end-of-life care can impact patient autonomy (Loewy).
4. **Test of Beneficence** must be kept in mind because it requires moral judgment from both physician and patient when discussing the best option for the best interest of the patient.

Improvements - Call to Action

1. Characteristics of medical futility have made it difficult to achieve a clear consensus.
2. An additional desirable feature is uniformity: futility policies should require universal guidelines on protocols of futility.
3. Educating doctors more about end-of-life care and dying so that they can learn to better talk about dying with patients/loved ones compassionately (Willmott).
4. A better way to avoid disputes over medical futility between physicians and patient families is to advocate for the use of advanced directives. This ensures patient autonomy and care if they so choose.

Sources

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