



Medical Futility: Balancing Patient Autonomy and Physician Integrity

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Autonomy, Integrity and the Goals of Medicine

In the early days of modern medicine, the physician's armamentarium against physical ills was a limited assortment of diagnostic tools and curative concoctions, and patients readily accepted what was offered. In the intervening years, scores of new techniques, treatments and technological devices have changed the prognostic outlook for many diseases once thought to be deadly, bringing a new concept to the examining table: the patient's right to refuse. Traditionally, the goals of medicine have been to heal and to relieve suffering and pain. In recent years, the principle of respecting patient choices has motivated the establishment of institutional policies that permit patients (or surrogate decision-makers) to exercise autonomy by limiting, refusing or withdrawing any unwanted intervention. The right to refuse treatment stems from our constitutionally protected

"liberty interest" and, in some states, is linked to our constitutional right to privacy.¹ These policies are generally limited to situations in which patients or their proxies refuse an intervention.

Indeed, our modern, market-driven economy has created something called a "health care consumer," further confusing physician and patient roles and presenting the healing art of medicine as something that can be bought and sold on demand. Truly, there are treatments that can be either healing, such as blepharoplasty for vision obstruction, or elective, such as the same procedure to combat a common side effect of aging.

However, what if a patient or proxy requests a treatment that will not be of benefit, such as antibiotics for a virus, or may even do harm, such as CPR on a patient in end-stage

cardiac disease with multi-system failure for whom dialysis is no longer working? As is common in moral and ethical theory, there is a complementary concept that stands at counterpoint and may limit individual autonomy: respect for professional integrity.

Respect for physician integrity dictates that medical practitioners provide treatments that balance any harms they may create with the good that they are expected to do a given patient. If the likelihood of benefit is practically zero, then virtually any risk is not justified. In analyzing physician-assisted suicide to ascertain why physicians are obligated to not perform actions that predictably will not offer benefit, the following elements of professional integrity become evident:

1. The ethical goals that define medical practice include healing and curing disease, promoting health and preventing disease, and relieving suffering caused by disease symptoms. If a treatment can be reasonably predicted to accomplish none of these, requiring a physician to offer it is to require them to act contrary to their goals of practice.
2. Physicians are obligated to adhere to high standards of scientific competence. Employing a treatment that predictably will not work deviates from that standard of competence.
3. Physicians are also obligated to represent standards of scientific knowledge truthfully to the public, claiming neither more nor less than what medicine can truly deliver. Reasonable people will conclude that if a physician offers a treatment, it must have some chance of working. Thus, physicians who employ futile treatments risk becoming quacks or frauds.
4. Physicians are justified in risking harm to patients only when the possible benefit outweighs the risk. Giving in to demands for futile treatments, especially those such as CPR that can cause pain, forces physicians to become agents of harm, not benefit.²

It is, however, difficult to accurately define and agree on the meaning of the term “futile.” Reflection on the usage of the term “futility” reveals three common usages:

1. **Physiologically Futile Treatment** in which the treatment that is requested will not produce the outcome desired.
2. **Futility Based on Scarce Resources** in which a physician or institution *may* consider a treatment that imposes enormous cost compared to the benefit it might yield.

3. **Normative futility** (which is often confused with physiologic futility) in which the burdens of treatment sought are felt, by the caregiver, to outweigh the benefits.³

Given that the term futility can be nuanced in so many ways, it is important to clarify what one means when making such a claim. If health care institutions attempt to create policy regarding futile interventions, they would also be advised to offer a definition of futile early on to clarify under what circumstances, exactly, such a policy might be invoked. Whereas a policy that deals only with physiologic futility might be defensible given that physicians are under no obligation to provide treatment that is not medically indicated, or a decision based on scarce resources might be defensible for a hospital with limited resources, one that ventures to justify refusal based on normative thought may be more difficult to justify.⁴

Institutional Futility Policies

An institutional policy regarding futile medical care should be designed to *supplement* rather than to *supplant* currently existing policies on limiting life-prolonging therapies and provide a conflict resolution mechanism to follow when a patient (or surrogate decision-maker) requests to start or continue an intervention that the primary attending physician assesses to be medically inappropriate (commonly referred to as “medically futile”). Such a policy affirms the value of integrity so long as appropriate, and thorough institutional review supports the determination of medical inappropriateness. It is suggested that procedures set forth in such a policy should be invoked only by the primary attending physician. Concerns on the part of other health care providers, hospital officials or family members should be addressed through other institutional mechanisms such as a biomedical ethics committee or patient ombudsperson. Before resorting to an internal, legalistic proceeding, guidelines should assure that all supportive resources – social work, behavioral health, ethics, etc. – have been utilized and that clear and compassionate communication between the attending physician and the patient/family has occurred. Communication is crucial. The primary attending physician must carefully describe: the nature of the ailment and the prognosis that includes severity of the illness and likelihood of functional recovery as well as survival; the options, including palliative care and hospice care; and the reasons that the requested intervention is considered to be inappropriate. Institutions should be willing to facilitate access to an independent medical opinion regarding the appropriateness of the intervention in question. Guidelines should provide ample opportunity for patients or their

surrogates to obtain advice or to transfer the patient to a different facility or practitioner.

An institutional policy on futile medical care that involves oversight by a group of individuals not directly involved in caring for the patient in question can provide two important checks and balances in physician management. On one hand, review and oversight can support a physician's medical determination and uphold the need to protect the vulnerable patient while upholding the integrity of the practice of medicine. On the other hand, oversight can protect against the physician's potential abuse of power and unilateral decision-making.

An institution developing guidelines for determining futile care should be cautioned to review state and federal statutes. In some states, such as Texas, laws were developed specifically to deal with this issue. In South Dakota, however, statutory guidance is limited to various statements embedded in our advance directive laws. Chapter 34-12D section 19, in particular, clarifies that "This chapter does not require a physician or other health care provider to take action contrary to accepted medical standards." What those "accepted medical standards" are, however, is not further defined.

In Summary

Recognizing medical futility affirms both the traditional goals of medicine and the moral value of physician and institutional integrity in discerning the limits of medical interventions. Respect for this integrity provides the basis for the right to refuse to provide a medically inappropriate intervention. It complements the right of patient autonomy that must be given both voice and effect in any forum for medical decision-making. This appeal to integrity is generally rooted in a combination of concerns such as avoiding harm to patients, avoiding provision of unseemly care, and just allocation and good stewardship of medical resources. Institutional policy regarding medically inappropriate treatment should effectively assign responsibility, promote communication and provide a reasonable timeline.

REFERENCES

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