



Futility: a perennial issue for medical ethics

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While the era following the Bland decision in 1993¹ might be thought of as the time when concepts such as ‘futility’ were placed under pressure and scrutiny, it’s an idea that has been debated for at least forty years. In a 1983 JME commentary Bryan Jennett distinguishes three kinds of reason why Cardiopulmonary Resuscitation (CPR) might be withheld:

‘... that CPR would be futile because it is very unlikely to be successful; that quality of life after CPR is likely to be changed to so poor a level as to be a greater burden than the benefit gained from prolongation of life, and that quality of life is already so poor due to chronic or terminal disease that life should not be prolonged by CPR.’ pp-142-143²

This crisp definition seems as applicable as it did then, but it was not the final word on the concept. Mitchell, Kerridge and Lovat explore, as others did in the post-Bland and Quinlan eras, how ‘futility’ might apply to those in a persistent vegetative state (PVS).³ They defend withdrawing artificial nutrition and hydration (ANH) when it ‘...offers no reasonable hope of real benefit to the PVS patient’ and note that this ‘would represent a significant shift in the ethical obligation owed by the doctor to the patient.’ p74 The ethical difference between that sense of futility and Jennett’s first sense of a ‘treatment being very unlikely to be successful’ was not lost on those critical of the withdrawal of ANH. Following the Bland decision, Finnis and Keown observed that doctors were now able to determine whether the life of someone in a PVS was worth living and decide that treatment could be withdrawn because treating that patient was deemed futile in the sense of not providing them with an improvement in their quality of life.^{4,5}

In addition to worries about the very different kinds of clinical judgement that can be described as futile, some have objected that the clinical use of the term risks being pejorative. Gillon reaches the view that

‘...futility judgments are so fraught with ambiguity, complexity and potential

aggravation that they are probably best avoided altogether, at least in cases where the patient or the patient’s proxies are likely to disagree with the judgment.’⁶ p339

Arguing in a similar vein, Ardagh objects both to the complexity in determining before the case that CPR won’t work and to the conceptual implication that futility means a failure of a treatment to benefit.⁷

Futility has continued to be debated in the literature since these and other critical analyses of its utility and coherence were published. This issue of the JME includes papers that re-examine issues that were flagged in earlier debates. Cole *et al* describe the predicament faced by ambulance clinicians (paramedics) when they decide that CPR is futile and when family members are present who would like everything to be done.⁸ This brings back into the light the issue of whether the judgement that a treatment is futile is a straightforwardly clinical or physiological assessment. They mention UK guidance that says

“‘Where no explicit decision about CPR has been considered and recorded in advance, there should be an initial presumption in favour of CPR.’ Clinicians are however, given discretion to make decisions not to attempt CPR where they think it would be futile.”

That, on the face of it, implies that first responders can make a judgement that CPR is futile, but the picture is muddled if we understand futility to be a judgement about the best interests of that patient. That judgement does imply, at the very least, a discussion with family members about what would be in that patient’s interests. So, clarity about which sense of futility is in play seems as critical as it did when Jennett wrote about it in the 1980s.

Vivas and Carpenter grapple with the futility issue that was also at the heart of the Bland decision and the withdrawal of ANH for those in a PVS.⁹ They say

‘How do we define treatment futility when a treatment is often effective in the strict physiological sense (restoring life) while being almost entirely ineffective in the larger, holistic sense—that is, it does not stop dying, merely delays and prolongs it?’

In the case of CPR they consider the argument that it might be an instance of a death ritual ‘... connected with religious beliefs and broader social values. In our technological society, even ‘physiologically futile’ resuscitation may have significant value as social ritual for the dying and their loved ones.’ They are sensitive to the risks inherent in medicine offering treatments that are highly unlikely to benefit that patient because it helps those around the patient. They suggest that this may be a vital need nonetheless and the issue is therefore whether there are better ways of fulfilling these ‘existential needs’.

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