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Editorial

"Futility" – too ambiguous and pejorative a term?

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In their paper on cardiopulmonary resuscitation (CPR) in this issue of the journal[1] Drs Hilberman and colleagues offer a corrective to the increasingly widespread assumption that CPR should always be carried out unless it is "explicitly refused or futile". They point out some difficulties even with explicit refusal as an absolute moral rule, and argue briefly that the ever more common declaration of futility is more complex than at first it appears, and not as helpful as is often claimed. Instead they call for a moral assessment of proposed CPR interventions on the basis of whether they are likely to provide significant net benefit for the patient, whether they are carried out with the actual or implied permission of the patient, and whether there is sufficient probable benefit to justify the social cost and opportunity cost of providing it both to various potential therapeutic groups and to individual patients within those groups.

The concept of futility is often wielded in medicine to trump proposals and requests for treatment that the trumping doctor wishes to reject on the grounds that they are unjustified. While it seems clear that doctors have no moral obligation to provide futile treatments and indeed where these are likely to cause burdens of one sort or another that they have a positive moral duty *not* to provide them, nonetheless 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. When such judgments are to be used as a basis for withholding or withdrawing potentially life-prolonging treatment, such as CPR, then they had better be made rather precisely, and preferably expressed in terms that are less ambiguous, complicated and distressing.

First then, the concept of futility is not an entirely clear one. It is clear that futility involves failure to achieve some objective or purpose – but there are countless failed endeavours that would not generally be regarded as futile, especially not when they are thought of prospectively, before they have failed, rather than retrospectively with the benefit of hindsight. Dictionaries indicate the sort of uses made of the concept but don't offer us any great precision – for example "serving no useful purpose, ineffective, fruitless" – or alternatively, "useless; frivolous" – or "incapable of producing any result; ineffectual; vain". Despite appearances to the contrary the etymology of the word has nothing to do with the word "utility" but rather derives from vessels that tend to spill or leak their contents. However *Roget's Thesaurus* links the term with the general concept of inutility (and thus with words such as uselessness, inefficacy, ineptitude, inadequacy, unfruitfulness, labouring in vain, even worthlessness and mere farce) and with the general concept of absurdity (including words such as "imbecility", "nonsense", "blunder", "muddle", "bull", "twaddle" and "moonshine"). And an "ostensive definition" of the term is given in William Gerhardie's depressing novel, called simply *Futility*, which evokes ineluctable and ever-deepening bourgeois gloom, hopelessness and social failure in early revolutionary Russia.

Given all this it is not surprising that use of the term in medical practice tends to be equally broad-ranging and equally negatively evaluative, even pejorative. It is not a good thing in medicine to do something futile to a patient, and we criticise a doctor if we say that what he or she has done, is doing or intends to do, is futile. This is hardly surprising since the main moral driving force of medicine is to do what is useful to the patient, so that to do what is useless, ineffective, fruitless, let alone to do what is *incapable* of being useful, effective or fruitful, is to fail to do what doctors are morally required to do.

Secondly, the term is complex. It involves assessments of outcomes of interventions in terms of value-free descriptions (for example whether or not restoration of heartbeat is possible); in terms of probabilities (how likely or probable are the outcomes); and in terms of values (how valuable or otherwise are the outcomes, and according to *whose* values – patients' or their surrogates', doctors', and other health professionals', managers', or society's values?)

In a contribution to an international consensus statement on forgoing life-prolonging medical treatment Professor Howard Brody distinguished three different medical uses of the term futility in relation

to CPR.[2] First, futile in the sense that resuscitation will fail to restore heartbeat; second, futile in the sense that though it will restore heartbeat the patient will remain permanently unconscious; and third, futile in the sense that though it will restore heartbeat and consciousness, nonetheless the patient will not survive long enough to leave hospital. Moreover in each case there is the further issue of what probability of correct prediction is needed for the judgment of futility to be made. Schneiderman and Jecker, for example, propose a ninety nine per cent probability of being correct[3] while Goldworth argues that there can only be objective certainty that a treatment is futile in those very rare instances when the probability of successful treatment is zero.[4]

Further illustrating the complexity of the use of the term, Brody went on to identify four increasingly contentious categories of so called "futility" judgments that doctors might make when deciding to withhold or withdraw treatment. The least contentious is futility in the sense of being (highly) likely to fail to achieve its physiological objective. Brody's second category of futility covers those treatments which may achieve their physiological objective but with consequences for the patient deemed unacceptable by the medical profession (for example unacceptable mutilation, loss of function or pain); his third category of futility covers treatments which may achieve their physiological objectives but which are likely to produce untoward consequences deemed unacceptable "by the vast majority of people"; and his fourth category covers the type of situation in which a doctor judges that a treatment will produce burdens that far outweigh its benefits, even though the patient disagrees, believing that the benefits outweigh the burdens.

Brody claims, in regard to the last category, that it is clearly wrong for the doctor either to call the treatment futile or to withhold it against the patient's wishes on those grounds. On the other hand, he argues that as far as the first category is concerned, almost all would support the doctor's withholding or withdrawing of interventions that are highly unlikely to achieve their physiological objectives – CPR ought not be started on a corpse at his or her funeral service. In between, the matter is controversial and requires, as the Appleton consensus statement puts it, "full and open discussion of the nature and extent of the 'futility' of the treatment with the patient or the patient's representative".[2]

Apart from the problem of multiple ambiguity, it is this tendency to produce hostility in cases of disagreement that is perhaps the strongest reason for avoiding use of the term "futile" and its cognates in the context of withholding or withdrawing potentially life-prolonging medical interventions. As noted above the term carries with it a strongly negative connotation – "uselessness" in the face of life-threatening disease is not generally appreciated, especially in doctors, and the natural anger of a dying person and his or her relatives is often directed not only at the interventions that fail to preserve life but also at the medical and nursing staff who carry them out. Staff are likely to be blamed even more, if they not only deliberately withhold or withdraw such attempts before death has actually occurred, but then, as it were, rub salt in the emotional wounds by using pejorative terms such as "futile" to describe the rejected attempts to preserve life.

Instead, the underlying fears and concerns of the patient or proxy who "wants everything to be done" to preserve life as long as possible have to be addressed sympathetically and with the express acknowledgment that producing significant net benefit for the patient with minimal harm is the mutual primary objective. Sometimes agreement will not be reached despite sympathetic attempts to explain why certain interventions are unlikely to produce such net benefits for the patient; or why they are too likely to produce unacceptable burdens of one sort or another. In such cases recourse to third party intervention seems the best and fairest way forward, either from clinical ethics committees or, if patients or surrogates prefer, from the courts.

However, agreement seems more likely to be achieved if pejorative terms such as "futile" are not applied to what the patient or the patient's surrogate is seeking and believes to be valuable. Some words in medicine – "hysterical" and "hypochondriac" could be added to "futile" – have acquired so much pejorative baggage that they are probably best regarded as medically obsolete, and consigned to the medical history books.[5]

References and notes

1 Hilberman M, Kutner J, Parsons D, Murphy D. Marginally effective medical care: ethical analysis of issues in cardiopulmonary resuscitation (CPR). *Journal of Medical Ethics* 1997; **23:** 361–7.

2 Stanley JM, ed. The Appleton consensus: suggested international guidelines for decisions to forgo medical treatment [**study edition**]. (Available from the author, c/o Program in Biomedical Ethics, Lawrence University, PO Box 599, Appleton, Wisconsin 54912, USA).

3 Schneiderman L, Jecker N. Futility in practice. *Archives of Internal Medicine* 1993; **153:** 437–41.

4 Goldworth A. Medical technology and the child. In: Thomasma D, Kushner T, eds. *Birth to death – science and bioethics.* Cambridge: Cambridge University Press, 1996: 79–84.

5 Within the large and growing literature on futility in medicine should be noted the entire issue devoted to the subject of *The Journal of Medicine and Philosophy*, volume 20, no 2, April 1995; the book by Jecker N and Schneiderman L, *Wrong medicine: doctors, patients and futile medicine.* Baltimore MD; Johns Hopkins University Press, 1995; and Robert Halliday's paper, Medical futility and the social context. *Journal of Medical Ethics* 1997; **23:** 148–53.