The issue of futile medical treatment is as old as medicine itself, going back to Hippocrates, who advised physicians “to refuse to treat those who are overmastered by their diseases, realizing that in such cases medicine is powerless.” Recognition that cardiopulmonary resuscitation (CPR) is ineffective in some cases led to suggestions that physicians should unilaterally refuse to provide CPR when they consider it futile but this option was strongly rejected by a Presidential Commission in 1983. Futility discussion was further stimulated by the case of Helga Wanglie, whose physicians tried to discontinue her life-sustaining treatments that they considered futile despite objections of her husband. Interestingly, they did not ask the courts to agree that the treatment was futile, they just asked for appointment of another proxy who would be more agreeable to their suggestions. The most recent high-visibility case was Terri Schiavo, whose husband considered her tube feeding futile because she was in a persistent vegetative state (PVS). This case was again decided on the basis of her proxy’s wishes despite religious statements proposing that feeding to individuals in PVS should be provided.

This long history of futility discussion indicates that futility is in the eye of the beholder. It is generally accepted that patients may refuse life-sustaining treatment, eg, amputation of a gangrenous leg, even if this treatment is not considered futile by health care providers. On the other hand, patients or their proxies may request treatments that health care providers consider futile, eg, tube feeding of individuals in PVS. In an article published in this issue, Cruz-Oliver et al try to make futility more objective by asking physicians what they use as a basis in their decision making. The authors, however, were asking physicians to choose between apples and oranges because selecting “patient-oriented futility” does not explain the reason why the physician considered the intervention futile, whereas the other options specified physicians’ basis of futility decisions.

Most physicians have chosen “patient-oriented futility” that depends on the patient’s goal. Despite this choice, almost all of these physicians were willing to decide if an intervention was futile in vignettes that did not contain patients’ goals, which indicates that they used other criteria for their decisions. Forcing physicians to select only one basis for futility decisions does not make sense because the basis for a decision may differ according to a patient’s condition. In addition, the selection did not include some other types of futility decisions, eg, quantitative futility based on probability of success, or resource-centered futility based on fair allocation of resources.

The nebulous nature of futility leads sometimes to disagreement between health care providers and patient/proxy about which treatment should be provided. The American Medical Association recommended a 7-step process for attempting to resolve the disagreement and some states included this recommendation in their laws. For instance Texas, in its Texas Advanced Directive Act, stipulates that ethics or medical committees should review the disagreement and if both parties do not agree with the decision of the committee the patient should be transferred to a facility that would grant the request of the patient/proxy. “If a provider cannot be found willing to give the requested treatment within 10 days, life-sustaining treatment may be withdrawn unless a court of law has granted an extension.” However, the court should grant an extension only if it “finds that there is a reasonable expectation that a physician or health care facility willing to provide life-sustaining treatment will be found if the extension is granted.” Thus, there is clear-cut limitation of time for which futile treatment would be provided.

Cruz-Oliver et al also tried to determine if age is a factor in physician-determined treatment futility. They found that in the whole sample of respondents age was not a significant factor for futility decisions when the vignettes were compared but younger physicians were more likely to rate treatment of aged individuals as futile. Despite these results, age may be considered a valid factor in deciding if a treatment is futile depending on the nature of the problem. Because there is evidence that age was not a determining factor in the results of CPR of hospitalized elderly patients, CPR should not be considered futile based on age as the main factor. On the other hand, treatment of prostate cancer clearly depends on the age of the patient, and chemotherapy that is indicated in a young patient may be considered futile in an aged individual.

“Futile treatment” is a shorter substitute to describe treatment that is ineffective from the point of view of either patient or health care provider, or treatment where the benefit is less than the cost; either individual burden for the patient or the cost for society. Although this term may be useful in professional publications, it may not help in communication between health care providers and patients/proxies. It is much more helpful to describe the benefits and burdens of individual interventions so the patients/proxies may decide if the intervention is in agreement with their goals. By avoiding the term “futile” it may be possible to prevent some disagreements.
between patients/proxies and health care providers that are based on different perceptions of the meaning of futility.

REFERENCES