Determination of "futility" in emergency medicine

DOI: 10.1067/mem.2000.106991

CONCEPTS

Determination of "futility" in emergency medicine

Catherine A. Marco MD*
Gregory L. Larkin MD, MSPH*
John C. Moskop PhD ‡
Arthur R. Derse MD, JD.§

From the Department of Emergency Medicine, St. Vincent Mercy Medical Center, Toledo, OH*; the Department of Medical Humanities, Brody School of Medicine, East Carolina University, and Bioethics Center, University Health Systems of Eastern Carolina, Greenville, NC ‡; and the Center for the Study of Bioethics and the Department of Emergency Medicine, Medical College of Wisconsin, Milwaukee, WI.§

Received for publication November 23, 1999.
Revision received February 10, 2000.
Accepted for publication February 22, 2000.

The opinions expressed in this article are those of the authors and may not reflect the official policies and opinions of the American College of Emergency Physicians. Dr. Marco, Dr. Moskop, and Dr. Derse are members of the ACEP Ethics Committee. Dr. Larkin served as committee chair in 1995-1997.

Address for reprints: Catherine A. Marco, MD, Acute Care Services, St. Vincent Mercy Medical Center, 2213 Cherry Street, Toledo, OH 43608-2691; 419-843-2452, fax 419-251-4478; E-mail: cmarco2@aol.com

Copyright © 2000 by the American College of Emergency Physicians.

0196-0644/2000/$12.00 + 0 47/1/106991

The practice of emergency medicine routinely requires rapid decisionmaking regarding various interventions and therapies. Such decisions should be based on the expected risks and benefits to the patient, family, and society. At times, certain interventions and therapies may be considered "futile," or of low expected likelihood of benefit to the patient. Various interpretations of the term "futility" and its practical application to the practice of emergency medicine are explored, as well as background information and potential application of various legal, ethical, and organizational policies regarding the determination of "futility."
Decisions regarding potential benefit of interventions should be based on scientific evidence, societal consensus, and professional standards, not on individual bias regarding quality of life or other subjective matters. Physicians are under no ethical obligation to provide treatments they judge to have no realistic likelihood of benefit to the patient. Decisions to withhold treatment should be made with careful consideration of scientific evidence of likelihood of medical benefit, other benefits (including intangible benefits), potential risks of the proposed intervention, patient preferences, and family wishes. When certain interventions are withheld, special efforts should be made to maintain effective communication, comfort, support, and counseling for the patient, family, and friends. [Marco CA, Larkin GL, Moskop JC, Derse AR. Determination of "futility" in emergency medicine. Ann Emerg Med. June 2000;35:604-612.]

See editorial, p. 615.

Introduction

Like their colleagues in many other specialties, emergency physicians must routinely consider the risk/benefit ratio of therapeutic interventions. Risk/benefit analysis may be applied to many relatively simple cases, for example, the decision whether to prescribe antibiotics for a patient with an upper respiratory tract infection. In such a case, physicians determine, based on experience and the medical literature, the probability that the cause is bacterial and that the patient will benefit from the administration of antibiotics. Physicians also consider the potential risks of prescribing antibiotics, which may include potential allergic reactions, drug interactions, cost of therapy, and the impact of overutilization of antibiotics on the development of antimicrobial resistance. Similarly, consideration of both risk and benefit should be applied to more critical decisions regarding such interventions as advanced airway management, invasive monitoring, cardiopulmonary resuscitation (CPR), and other critical care interventions.

In recent years, commentators have argued that the potential for benefit of certain interventions is so remote that physicians may, or even should, refrain from undertaking these interventions, even if patients or families request or demand them. These arguments, which appeal to a concept of medical futility, have evoked a lively ongoing debate with other patient advocates who question whether an appeal to futility can serve as a legitimate and sufficient reason for unilateral action by physicians to withhold or withdraw treatment.

Although the term "futility" has met with considerable difficulties and inconsistencies in interpretation, and debate about its moral force continues to rage, determination of the likelihood of benefit to the patient remains crucial for decisionmaking in emergency medicine. A background of conceptual and moral positions regarding futility is briefly reviewed, and the role of futility judgements in emergency medicine is considered, including the policy statement of the American College of Emergency Physicians (ACEP) on Nonbeneficial ("Futile") Emergency Medical Interventions.

The concept of futility

The term "futility," although commonly used, is fraught with difficulties in definition and interpretation. The word "futile" is derived from the Latin futilis, meaning "leaky." According to Greek myth, the daughters of King Danaus were condemned by the gods to carry water in sieves, a futile task. As Caplan has noted, futility judgments are about "odds and ends," that is, a futile effort must have very low odds of achieving the desired ends. Thus, each futility judgment has a quantitative aspect (how low are the odds of success?) and a qualitative aspect (what are the desired ends?).

Scholars have identified a variety of different standards for both the quantitative and qualitative aspects of futility. For example, Brody and Halevy review 4 different definitions of futility in the context of resuscitative efforts: (1) physiologic futility (failure to produce any physiologic response), (2) imminent demise futility (failure to prevent death in the very near future), (3) lethal condition futility (failure to affect an underlying lethal condition that will result in death in the not too distant future), and (4) qualitative futility (failure to lead to an acceptable quality of life). Each
successive definition in this series applies the concept of futility to a broader and more controversial group of patients.

A widely cited 1990 article on futility by Schneiderman et al\(^3\) proposes a definition of medical futility, with both quantitative and qualitative aspects. According to this definition, a treatment is futile if empirical data demonstrates a less than 1% chance of success, or if the treatment "merely preserves permanent unconsciousness" or "fails to end total dependence on intensive medical care".\(^3\)\(^16\)\(^17\)

Given this variety of proposed definitions, health care professionals may interpret futile interventions as those that carry an absolute impossibility of successful outcome, a low likelihood of success, a low likelihood of survival to discharge from the hospital, or a low likelihood of restoration of meaningful quality of life. Several authors have demonstrated that there is no consensus among physicians about the meaning of futility.\(^7\)\(^15\)\(^18\)\(^19\) Because of continuing controversy over the meaning of futility, it may be wiser to avoid the term and to refer instead to interventions as "nonbeneficial," "ineffective," "medically inappropriate," or "having a low likelihood of success".\(^5\)\(^18\)\(^20\)

Moral arguments

Several major moral arguments have emerged in the continuing debate over futile or nonbeneficial treatment. This section briefly reviews arguments offered by both proponents and opponents of appeals to futility in medical decisionmaking.

"Pro-futility" arguments

Beginning in the late 1980s, authors began to appeal to the concept of futility as a justification for limiting medical treatment despite patient or family demands that it be provided. Early work by Blackhall,\(^1\) Tomlinson and Brody,\(^2\) and Hackler and Hiller\(^5\) focused on the issue of resuscitation and asserted a right of physicians to withhold resuscitation attempts judged to be futile. Guidelines proposed by the Hastings Center\(^21\) and the American Medical Association (AMA) Council on Ethical and Judicial Affairs\(^22\) recognized decisions to forgo treatments based on physiologic futility. Other authors proposed criteria for discontinuing prehospital resuscitation efforts.\(^23\)\(^24\) In their 1990 article, Schneiderman et al\(^3\) argue that physicians may apply futility criteria to withhold or withdraw care without patient approval. These and other proponents of the concept of futility offer arguments based on professional integrity, professional expertise, and responsible stewardship of scarce resources.

The argument from professional integrity asserts that physicians should not be required to violate their own professional moral standards by providing treatments they believe to be futile or harmful. Forcing physicians to provide such treatment would violate their integrity as independent moral agents and reduce them, as Paris and Reardon\(^4\) observe, to "an extension of the patient's (or family's) whims, fantasy, or unrealizable hopes and desires."

A second pro-futility argument points out that patients and families rely on their physician's expertise in assessing the patient's condition and recommending reasonable treatment alternatives. If a physician judges a particular intervention to be futile, it is generally not a reasonable treatment alternative and thus should not be presented to the patient. However, such judgments should be based on sound scientific evidence, not on individual opinion or bias.\(^26\) Reliance on physician expertise is especially vital in emergency situations requiring rapid assessment and initiation of appropriate treatment.

A third pro-futility argument maintains that physicians have a duty to make good use of the material, financial, and human resources under their control in the provision of health care.\(^25\) Emergency physicians may personally provide, order, or supervise a wide variety of treatments in a variety of settings, within the emergency department, in the out-of-hospital setting, or elsewhere in the hospital. Providing futile care, however, wastes resources, because it cannot achieve its desired end. Thus, physicians should not administer or order futile treatments, thereby preserving resources for situations in which they can confer a benefit, and honoring their professional duty to other patients.
A number of authors have offered versions of this argument. For example, Murphy and Matchar\[27\] suggest that both medical and economic factors be considered when making decisions regarding life-sustaining therapy. Lantos\[28\] states that "given limited resources, it is ethically justifiable to limit access to treatments that are expensive and offer minimal benefit...decisions by doctors to curtail use of those treatments are socially responsible." Several authors suggest that CPR not be considered a part of the standard of care for certain patients with expected poor outcomes.\[5\] \[29\] \[31\] The time may come when the United States may need to emulate other countries, where the principles of stewardship and justice are applied more explicitly, as scarce health care resources must be carefully used for the maximal societal benefit.\[32\] \[33\]

"Anti-futility" arguments

Critics of the limitation of treatment based on physician judgments of futility offer arguments based on respect for patient autonomy, prognostic uncertainty, and the absence of social consensus regarding futility standards.\[6\] \[9\] \[34\]

Existing moral and legal precedents, such as the doctrine of informed consent, give patients substantial control over their own health care. Patients or their families may have very different opinions from their physicians about what goals of treatment or what odds of a successful outcome are worth pursuing. When such differences of opinion occur, this argument concludes, respect for patient autonomy should incline physicians to honor patients' preferences regarding treatment.

Regarding related issues, the AMA Council on Ethical and Judicial Affairs stated that "the social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the choice of the patient should prevail."\[35\] One more extreme viewpoint is that "even the irrational choices of a competent patient must be respected if the patient cannot be persuaded to change them."\[36\] The concept of autonomy has particular ramifications for emergency medicine, where time and information are often limited. The realization of the ideal may not be possible in a timely fashion. Because patient wishes and competence often cannot be established rapidly or conclusively, decisions must sometimes be made based on physician judgment regarding potential medical benefit, and a presumed respect for autonomy of the patient.

A second anti-futility argument appeals to the difficulty of making precise and accurate predictions that medical treatment will have no beneficial effect. Unless physicians can make highly confident predictions about the outcome of a treatment, they cannot forgo treatment on the grounds that it is futile. However, studies of critically ill patients conclude that available prognostic measures usually cannot predict outcomes like death with high levels of probability.\[37\] \[39\] The widespread interest in evidence-based medicine suggests that much of current medical practice remains unproven. Thus, physicians often lack sufficient evidence to make treatment decisions on the basis of futility. Particularly in emergency medicine, where an established patient rapport and familiarity with long-term conditions and prognoses are lacking, predicting outcomes may be problematic.

A third anti-futility argument observes that more than 10 years of debate have not yet produced a societal consensus on the question of futility. Instead, major scholarly and public differences of opinion persist regarding the legitimacy of most of the proposed criteria for futile treatment. In the absence of social consensus, this argument concludes that such criteria should not be imposed on unwilling patients or their representatives.

Decisionmaking in emergency medicine

In view of the persuasive moral arguments both supporting and challenging the physician's authority to make and act on futility judgments, resolving questions about futile treatment remains a difficult task. Critical care choices in the ED carry special significance because of the momentous potential consequences of administering or withholding interventions. Clinical situations in emergency medicine may present particular challenges in moral decisionmaking, especially in situations where insufficient information is available, surrogates are unavailable, or there is conflicting information. Despite the above limitations, emergency physicians should seek to base their treatment decisions on well-established research results, patient and family wishes, and professional judgment.
When considering administering or withholding critical care interventions, risks and benefits should be carefully considered. The primary goals of critical care interventions are to preserve life and restore health to the patient. Other less tangible benefits to family and friends may accrue, including reassurance, resolution of guilt, and provision of additional time for acceptance of bad news. Some defend the societal benefit of teaching resuscitation practices and procedures in resuscitation settings. Of crucial importance is the principle of continued care for the patient and family, even if certain medical treatments are withheld. Palliative care, communication, and counseling with the patient, family, and friends may be of greater benefit near the end of life than technologically advanced interventions.

One critical care intervention commonly used by emergency physicians is attempted resuscitation in response to cardiopulmonary arrest. In a recent national survey of 1,252 emergency physicians, most respondents (55%) reported that they had attempted resuscitation more than 10 times in the past 3 years, despite their professional judgment that the effort would be futile. If the respondents' judgments about futility were accurate, these resuscitation attempts provided no medical benefit, but they did consume substantial resources, considering not only supplies, but time, effort, and risk incurred by health care providers. Why, then, do emergency physicians often attempt resuscitations that they believe to be futile?

Other responses in this survey suggest several potential reasons. A large majority of respondents (94%) reported that legal concerns influence their resuscitative practices. Respondents also commented on the dearth of national guidelines for initiating and withholding resuscitation. Lack of authoritative guidelines or policies and the fear of liability, together with the existence of certain institutional policies suggesting resuscitation in the absence of prior do-not-resuscitate (DNR) orders, may provide strong incentives for emergency physicians (and other health care professionals) to attempt resuscitation despite expected futility. How, then, can these incentives be overcome to prevent resorting to futile efforts at resuscitation?

Futile care policies

One antidote to the irrational and profligate use of resuscitative technology is the establishment of scientifically informed policy or professional consensus guidelines. Various professional associations and other groups have, in recent years, offered proposals designed to limit the use of futile treatment. Prominent examples include statements regarding futility from the 1992 National Conference on Cardiopulmonary Resuscitation and Emergency Cardiac Care, from the AMA's Council on Ethical and Judicial Affairs, and from ACEP. Each of these policies is reviewed to determine whether they offer useful guidance for ED decision about resuscitation attempts or other interventions.

1992 National Conference Recommendations

Recommendations regarding futility were included in the report of the most recent National Conference on Cardiopulmonary Resuscitation and Emergency Cardiac Care in 1992 (Emergency Cardiac Care Committee and Subcommittees). Although the report recognizes that physicians should not be obligated to provide futile care, it goes on to say that "unilateral decisions by physicians to withhold or terminate resuscitation are justified only when it is futile in a strict sense." The report specifies 3 circumstances in which appeal to futility is sufficient to justify a decision to withhold or terminate resuscitation:

1. Appropriate basic life support (BLS) and advanced life support (ALS) measures have already been attempted without restoration of circulation and breathing.
2. No physiologic benefit from BLS and ALS measures can be expected because a patient's vital functions are deteriorating despite maximum therapy.
3. No survivors after CPR have been reported under the given circumstances in well-designed studies.

Although terms such as "maximum therapy" are poorly defined, these "strict" criteria appear to be relatively uncontroversial; however, they are not likely to apply to many decisions about initiating resuscitation efforts in the ED. Rarely will emergency physicians be aware that a patient has had an
arrest despite maximum therapy or that CPR has never been successful in a given circumstance.

**AMA Council on Ethical and Judicial Affairs**

In a 1999 report, the AMA Council on Ethical and Judicial Affairs recommends a "process-based" approach to futility determinations in end-of-life care. Drawing on an earlier policy proposal by Halevy and Brody, this AMA report outlines 7 procedural steps for resolving disagreements between physicians and patients or proxies regarding futile treatment. Some of the proposed steps include:

1. Deliberation and resolution. Attempts should be made between patient, proxy, and physician to determine prior understandings regarding appropriate care and futile care.
2. Joint decisionmaking should be made between physician and patient or proxy.
3. Assistance of a consultant or patient representative may be useful in the resolution of defining appropriate limits of care.
4. An institutional committee (ie, ethics committee) may be involved to aid in the resolution of defining appropriate limits of care, to the satisfaction of all parties involved.

This procedural approach may hold great promise in nonemergency treatment choices, but it has little to offer in emergency resuscitation decisions, for obvious reasons. Each of the above steps requires considerable time, but there is little or no time available for deliberation, consultation, or transfer when an emergency patient has a cardiopulmonary arrest.

**ACEP Policy Statement on Nonbeneficial ("Futile") Emergency Medical Interventions**

Acting on a recommendation from its Ethics Committee, the Board of Directors of ACEP approved a policy statement on futile treatment in 1998. This policy statement asserts ACEP's belief that "physicians are under no ethical obligation to render treatments that they judge have no realistic likelihood of medical benefit to the patient." The policy statement goes on to state that emergency physicians' judgments should be unbiased, based on available scientific evidence and societal and professional standards, and sensitive to differences of opinion regarding the value of medical intervention in various situations.

This ACEP policy statement provides support for emergency physicians confronting resuscitation decisions in one important way, namely, it throws the weight of emergency medicine's most important professional association behind the claim that there is no moral obligation to provide futile care. Official endorsement of this position may calm some physicians' fears of liability for withholding futile resuscitation efforts. The policy statement's support for physicians' futility judgments is not unconditional, however. Rather, it asserts that these judgments should be based on available scientific evidence and societal and professional standards. Thus, it raises questions about what evidence and standards exist regarding the use of resuscitation. This policy statement may be used by emergency physicians to aid in decisionmaking, and supports the position that the withholding or termination of nonbeneficial interventions (in appropriate circumstances) may be justified.

Although the establishment of national guidelines and policies may be helpful in providing general guidance, and in alleviating certain medicolegal concerns, such general guidelines and policies have important limitations. General guidelines cannot anticipate and address all of the relevant features of a particular case, with its unique aspects of history, prognosis, premorbid considerations, quality-of-life issues, advance directives, family concerns, and so on. The individual physician should take each of these features into account in deciding how to proceed.

**Legal issues**

Refusing to provide treatment that is considered by physicians to be futile has been a vexing problem not only for clinicians and ethicists, but also for the courts. Courts have stated that physicians do not have an obligation to provide care that is futile. However, these statements have been made in cases where patients or family agreed with the physicians' decision to withdraw a treatment that had been determined to be futile. In these cases, the courts' support of the patient's right to refuse treatment
was further buttressed by arguments that physicians also did not have an obligation to continue futile treatment. Additionally, no precedent law supports a patient's right to demand treatment that physicians determine is ineffective.

However, no clear legal consensus has emerged, in the few publicized cases where physicians and the patient or family members have disagreed regarding the medical effectiveness of an intervention and whether to withhold or withdraw it. These cases have been, for the most part, trial court judgments, which do not set precedents for other courts. Nonetheless, 3 cases have provided benchmarks for discussion.

The first case centers on Helga Wanglie, an 87-year-old woman who, after having a respiratory arrest secondary to emphysema, had respirations assisted by a ventilator and then was in a persistent vegetative state. After months of ventilator treatment without recovery, her attending physician believed that further ventilation offered no benefit and recommended withdrawing ventilator support. Her husband, who was her guardian, wished to continue ventilation. Mrs. Wanglie's physician then petitioned the trial court to replace the husband as his wife's guardian. The court did not find that the husband had violated his duty to act in his wife's best interest by insisting on continued treatment. Although this case has been often discussed in the context of medical futility, in fact, the case merely demonstrated the reluctance of the courts to replace a spouse who is acting as guardian, without showing that the spouse/guardian is acting in bad faith or against the best interests of the patient.

In a second case, the patient, Mrs. Gilgunn, was comatose after a hip fracture and seizures, and her physicians determined that she was dying from end-stage chronic obstructive pulmonary disease. Her daughter insisted on continued ventilation and CPR. However, after an ethics committee consultation, a DNR order was written, ventilator support was withdrawn, and Mrs. Gilgunn died. A trial court jury determined that the physicians had not committed malpractice by failing to heed Mrs. Gilgunn's daughter's wishes. Although this trial court case has been taken by proponents of futility to indicate that courts and juries are reluctant to second-guess a physician's determination of futility, physicians should be cautious in using any trial court decision as an indication of what other trial courts are likely to determine.

In the third case, "Baby K" was an anencephalic infant who had been discharged from the hospital. Attending physicians did not believe that further treatment, including resuscitation and intubation, was warranted. However, Baby K's mother wanted maximal treatment for her child. The hospital sought a declaratory judgment to withhold ventilation despite the mother's objection. A federal appeals court interpreted the Emergency Medical Treatment and Active Labor Act (EMTALA) to apply, determining that the plain language of the statute required that a child—even an anencephalic child—in respiratory arrest presenting to the ED must be treated or stabilized and transferred. This case, which sets a precedent for those states in the 4th Federal Circuit Court of Appeals (Virginia, West Virginia, Maryland, North Carolina, and South Carolina) suggests that EMTALA may have important ramifications for considerations of futility. However, the attending physicians in this case did not claim that intubation would be ineffective. Instead they claimed that because of the untreatable nature of the underlying condition, intubation would serve no long-term, worthwhile purpose. Thus, a more conservative reading of the case suggests that even in the ED, ineffective treatments need not be offered. It should be noted that this case applies only to the jurisdiction of the 4th Federal Circuit Court of Appeals, and that EMTALA does not necessarily dictate which interventions and procedures must be performed. The individual physician must make the determination of which interventions are appropriate in each particular case.

Several conclusions can be drawn from the initial judicial analysis of cases related to the determination of futility. First, for emergency physicians in most of the country (ie, outside the 4th Circuit), there is no controlling federal or state law. Second, the plain language of EMTALA requires treatment or stabilization and transfer of patients who present to the ED for treatment. Third, courts and juries seem to be reluctant to authorize treatment withdrawal over the objections of family members, but also seem to be reluctant to hold physicians liable for exercising medical judgment of a treatment's ineffectiveness. Fourth, physicians should be extremely careful in determining medical ineffectiveness, since such decisions may be subject to legal scrutiny.

Although medicolegal concerns should be carefully considered, there are significant limitations of the law in the resolution of ethical issues. Laws and rulings may differ significantly across regions.
Numerous clinical situations involve unprecedented legal controversy. The law is limited procedurally as a means of dispute resolution, and often does not address general principles. Thus, physicians should use a strong ethical framework when making decisions. In addition, acting in the best interest of patients and society may serve as a reasonable mediational argument. Emergency physicians should have an understanding of both ethical principles and the law, and should carefully consider both when making ethical judgments.

Resuscitation: Evidence and standards

If judgments about when resuscitation is futile are to be guided by evidence and standards, accurate knowledge regarding scientific evidence and professional standards is a prerequisite. A large amount of data regarding the outcomes of resuscitation has been accumulated over the past 30 years. Recent reviews report widely variable survival rates for victims of cardiac arrest, dependent on a number of factors, including time elapsed since arrest (down time),[54] [55] presenting rhythm,[56] [57] underlying medical condition,[58] response to out-of-hospital ALS protocols,[59] [60] age,[61] and long-term care.[62]

Overall, survival for victims of cardiac arrest to hospital discharge has been estimated between 0% and 16%,[63] [64] Certain identifiable groups of patients have survival rates approaching 0%, for example, residents of long-term care facilities with unwitnessed arrests.[62] Despite this relatively low success rate, hospital policies (and out-of-hospital policies for emergency medical services providers) typically suggest or mandate resuscitation for all patients except those with prior do-not-attempt-resuscitation orders or clear signs of death, such as rigor mortis or dependent lividity.

Although several commentators recommend a change in policy away from standing orders for resuscitation, social and institutional policies still suggest resuscitation attempts for most patients.[65] [66] Current standards thus appear to constrain emergency physicians’ ability to forgo resuscitation attempts they judge to be futile. How should physicians respond to this situation?

Two courses of action suggest themselves. First, unnecessary and unwanted resuscitation attempts might be prevented by the wider dissemination and use of advance directives, especially living wills and out-of-hospital or “universal” do-not-attempt-resuscitation orders. In the above-cited study of resuscitation practice by emergency physicians, more than 95% of respondents cited the presence of advance directives as having an “important” or “very important” effect on resuscitation decisions, and 78% of respondents reported that they always honor legal advance directives.[44] It is unclear why as many as 22% do not honor legal advance directives, although other data suggest this may be secondary to medicolegal concerns. It may appear that some physicians are willing to commit assault and battery by attempting resuscitation for a patient with an advance directive, rather than face potential litigation for withholding resuscitative efforts. Advance directives thus appear to provide emergency physicians with the knowledge of patient wishes and the legal authorization they require to withhold unwanted, hence inappropriate, resuscitation attempts. Because only an estimated 15% to 20% of Americans have completed advance directives,[71] [72] improved compliance with documentation of patient wishes would have great impact on the actions of health care providers. However, that reliance on advance directives in forgoing resuscitation does depend on the patient’s prior decision to limit treatment as recorded in the directive. Patients who desire all life-sustaining treatment presumably will not complete advance directives, and thus physicians caring for these patients will not be able to rely on advance directives to withhold resuscitation. Additional efforts toward communication with patients and families before, and during, resuscitation attempts, regarding advance directives is of paramount importance.

Second, emergency physicians may seek to change existing social and institutional policies mandating resuscitation efforts. In place of standing orders for resuscitation, policies might be adopted to give providers more discretion to determine whether resuscitation efforts are futile given the patient’s specific condition. Implementing such a change may be an uphill battle, because it goes against the grain of decades of public and professional education stressing the value of CPR as a life-sustaining intervention. Additional support for policies limiting use of resuscitation may come from recognition of its high cost together with increased pressure for cost-containment.[73]

In summary, after more than a decade of intense debate, futility remains a controversial topic in US medicine and bioethics. Scholars have proposed a variety of definitions of futility and marshaled a variety of arguments for and against its use in medical decisionmaking. Emergency physicians frequently encounter decisions regarding the provision of care they believe to be clinically nonbeneficial. Because of constraints of time, information, and other limitations, judgments in

Emergency medicine are particularly challenging. Procedural approaches common in other medical contexts, such as family conferences and ethics committee consultations, are impractical in emergency situations. In all aspects of emergency medicine, decisions should be made regarding various interventions and therapies, based on the expected risks and benefits to the patient, family, and society. Determinations of the expected benefit should be based on scientific evidence regarding the likelihood of benefit, and not on individual bias regarding quality of life, magnitude of benefit, or other subjective matters.

Emergency physicians are under no ethical obligation to provide treatments they judge to have no realistic likelihood of benefit to the patient. In fact, there may be an ethical obligation to withhold such treatment, particularly if it entails significant risk or cost. Evidence suggests, however, that emergency physicians may be reluctant to forgo treatment efforts without clear support for this decision in policy, practice standards, or the law. In making decisions regarding withholding or terminating clinically nonbeneficial treatments, emergency physicians should take into account the following considerations:

1. Scientific evidence of likelihood of medical benefit (based on similar cases)
2. Likelihood of other benefits (including potential intangible benefits, such as family needs, communication, and so on)
3. Patient preferences (if available)
4. Family wishes (if available)
5. Potential risks of the intervention (including adverse or suboptimal outcomes)

When an intervention is withheld, special efforts should be made to maintain effective communication, comfort, support, and counseling for the patient, family, and friends. These nontechnical, humanistic efforts cost little, and yet retain the promise of a treasured benefit for all concerned. Caring is one intervention that is never futile.

References


47. Halevy A, Brody BA. A multi-institution collaborative policy on medical futility. *JAMA.* 1996;267:571-574. Citation


49. *Barber v Superior Court,* 195 Cal Rptr 484 (Ct App 1983).

50. *In re Wanglie,* No. PX-91-283 (Minn 4th Dist Ct Hennepin County, July 1, 1991).

51. *Gilgunn v Massachusetts General Hospital.* No. SUCV92-4820 (Super Ct, Suffolk County, Mass, Apr 21, 1995).


Copyright © 2011 Elsevier Inc. All rights reserved. - www.mdconsult.com