MEDICALLY FUTILE THERAPY GUIDELINES

I. PURPOSE

To suggest a set of guidelines and processes for dealing with medically futile therapy.

II. INTRODUCTION

Law and regulation have codified the right of patients to refuse medical intervention. Health institutions have developed processes for resolving conflict in this area. It is now necessary to broaden the discussion to include the reciprocal situation; that is, the circumstance in which a responsible physician is of the professional opinion that a medical intervention is inappropriate and should be withdrawn or withheld, however, the patient (or surrogate decision-maker) feels that the intervention should be pursued. To further this discussion, the Medical Society of New Jersey (MSNJ) proposes a working definition of medically futile therapy and a procedure to be followed in cases where conflict persists between physician and patient/surrogate.

III. DEFINITION

Futile medical therapy can be considered to be any treatment that cannot within reasonable likelihood cure, palliate, ameliorate, or restore a quality of life that would be satisfactory to the patient. This includes any treatment in which the burdens greatly outweigh any chance of success or benefit to the patient.

The above definition is deliberately vague because it is meant to include not only those therapies in which the success rate is nil but also those therapies where the success rate may approach zero or which have a low success rate coupled with a high likelihood of pain or suffering. Futility decisions must result from a shared decision-making process between physician and patient/surrogate. The physician supplies objective data about the effectiveness of the proposed treatment and the patient/surrogate ponders whether the treatment is "worth it" based on the patient's goals for treatment, life values, interest in risk-taking, etc. Because of the pluralism of our society, individuals may differ in their judgment about whether a particular treatment is futile. To honor this pluralism of values we focus on a process that may aid the shared decision-making.

IV. PRINCIPLES

1. Concepts of medical benefit or burden are value-laden; there always is an element of uncertainty; physicians should not substitute their own values for those of the patient.
2. When a surrogate acts on behalf of an incompetent patient it should be in terms of what would be the patient's own choice. This choice is binding if the patient's specific wishes are stated in an advance directive.

3. Apparent conflicts between physician and patient/surrogate over treatment decisions frequently are the result of miscommunication. The patient/surrogate who demands a medically inappropriate treatment may not understand the diagnosis/prognosis. The physician who believes the patient would be accepting great pain/suffering for minimal chance of success may not understand the patient's goals or values. The conflict resolution process must foster clear communication among the parties involved.

4. A trial of treatment should be considered in situations where the chance of success or the amount of burden tolerable is not clear. Withdrawal of treatment after a trial is ethically and legally no different from withholding treatment in the first place and may give all parties the satisfaction of having tried.

5. Any moral obligation to treat diminishes proportionately as medical effectiveness decreases. A physician is not obligated to provide futile treatments or those that compromise personal or professional integrity. At the same time, the physician must not abandon the patient. Transfer to another physician should be facilitated in cases of unresolved conflict.

6. To engender trust, the cornerstone of the doctor-patient relationship, the physician must always advocate for the patient. If the physician has any allegiances (to hospital, third party payers, etc.), which could appear to represent a conflict of interest with the patient, these must be openly acknowledged and set aside.

7. Financial issues concerning treatment should not be mixed with questions of futility. Lack of reimbursement for a treatment should be acknowledged as a monetary decision, which is different from a decision based on futility. Questions of reimbursement should be addressed in the business and political arena, not at the bedside.

V. SUGGESTED PROCESS FOR SHARED DECISION MAKING REGARDING TREATMENTS THAT MAY BE FUTILE (Table)

Table. Attending physician clearly states prognosis and care plan [proposed treatment]