

ETHICS MAN Daniel K Sokol

The slipperiness of futility

When clinicians deem an intervention to be futile, what do they actually mean?

He was shot in the back. The surgeons could not save him. He lay in bed, unconscious, his life ebbing away as blood trickled down tubes to large jars at the base of his bed. As cardiopulmonary resuscitation would have been futile, we wrote a “Do not attempt resuscitation” order. The case reminded me of the etymology of the word “futile.” “Futiles” in Latin means “leaky.” The patient was leaking blood from various wounds, and nothing could stop it.

At a recent examiners’ meeting, a professor of surgery admitted that he would have got the ethics question wrong. The question concerned the definition of futility. “So how would you define futility?” I asked. He paused and, like Humpty Dumpty in *Through the Looking Glass*, answered: “Something is futile if I say it is.” This remark highlights the semantic slipperiness and subjectivity of the term “futile.” Yet, in the clinical frontline, futility, coated with a veneer of objectivity, is often used as a moral trump card, a dismissive pronouncement to end all discussion: “I’m sorry. We’re stopping aggressive care. It’s futile.”

Psychiatrists must sigh in frustration when asked whether a patient has capacity. The capacity to decide what? Similarly futility is not free floating but linked to a specific goal. Prescribing antibiotics for a viral illness is physiologically futile, but if your goal is to leave the surgery in time for the first aria in *Don Giovanni* then it is not (although this would still be a breach of your duty of care).

Futility, then, is goal specific, and when you next hear colleagues say that such and such is futile you can surprise them and ask, “Futile with respect to what?”

When teaching this subject to medical students I shuffle a pack of playing cards, select a card at random, and ask whether it is futile for them to guess the identity of the card. Some say yes, others say no, and once in a blue moon a statistically minded student

will ask if the two jokers are included in the pack. Never is there unanimous agreement. The point of the exercise is to illustrate the variability of our quantitative assessment of futility. Some scholars have suggested that an intervention is futile if it has not worked in the last 100 cases. Under that definition, guessing the card would not be quantitatively futile. Even if we accept this somewhat arbitrary “last 100 times” rule, in practice the problem is that it is rarely possible to know whether an intervention has worked the last 100 times, especially as no two cases are identical.

The students who believe in the futility of naming the card still venture a guess if tempted by a £50 cash prize. The perceived futility of the exercise does not translate into a refusal to try. The reason is that there is no cost associated with the guess. The benefit is potentially significant and the cost minimal. As Kite and Wilkinson point out, sometimes the reason why clinicians withhold or withdraw an intervention is not because it probably won’t fulfil its purpose but because it will cause harm or deprive others of benefit. An intervention can be simultaneously futile, harmful, and wasteful.

One of the saddest cases I have seen involved a woman so viciously mauled by dogs that she was left in a vegetative state. When considering her resuscitation status, one of the doctors stated that, on the grounds of futility, she should not be resuscitated. When probed further, it emerged that the doctor believed that the patient’s quality of life was so awful that cardiopulmonary resuscitation was not medically indicated. This is another type of futility: qualitative futility. It is based on a subjective evaluation of whether the goal of the intervention is worth while.

Although ethically aware clinicians need not be familiar with the vast literature on the concept of futility, they



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might wish to remember the following four points:

- Futility is goal specific.
- Physiological futility is when the proposed intervention cannot physiologically achieve the desired effect. It is the most objective type of futility judgment.
- Quantitative futility is when the proposed intervention is highly unlikely to achieve the desired effect.
- Qualitative futility is when the proposed intervention, if successful, will probably produce such a poor outcome that it is deemed best not to attempt it.

When using the term, clinicians may be referring to several types of futility—for example, that an intervention is highly unlikely to achieve the goal (quantitative futility) and also that the goal itself is undesirable (qualitative futility). As futility is so rhetorically powerful and semantically fuzzy, doctors may find it helpful to distinguish between physiological, quantitative, and qualitative futility. This classification reveals that a call of futility, far from being objective, can be coloured by the values of the person making the call. Like “best interests,” “futility” exudes a confident air of objectivity while concealing value judgments.

On a practical note, clinicians should be wary of using the word “futile” in front of patients and relatives. As Jonsen, Siegler, and Winslade propose in *Clinical Ethics*, it may be better to think in terms of proportionality or “the balance of expected benefits over burdens imposed by continued interventions.” Furthermore, “futile” suggests that nothing can be done. Recall the ancient medical wisdom: “To cure, sometimes. To relieve, often. To comfort, always.” There is always something to be done.

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