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FUTILITY: REVISITING A CONCEPT OF SHARED MORAL JUDGMENT

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When caring for patients with end stage illness there tends to be universal agreement that overly aggressive treatment should be discouraged or limited when death is near and when further intervention would be futile or otherwise inflict undue suffering on the patient (1; 2; 3). The modern ability to delay the natural course of dying, however, has challenged the ability to distinguish at what point in the trajectory of disease it is appropriate, and perhaps morally required, to consider less vigorous disease treatment in favor of symptom oriented and patient focused plans of palliative care (4). This paper reflects on futility, not as an objective criteria of facts and prognosis, but as a concept that promotes patient interest when treatment becomes excessively burdensome. A prudent balancing of medical effectiveness, as determined by the physician, and the burdens and benefits of treatment, as identified by the patient, provides a means by which to seek a clinical judgment within the context of the healing relationship as to whether continued treatment is warranted.

From an ethical and theological standpoint it has generally been recognized that respect for human dignity requires certain constraints when treatment is excessively burdensome to the patient (5; 6). The ethical distinction between "ordinary" and "extraordinary" treatments takes into consideration whether ongoing emotional and physical discomfort, risk, cost, or other burdens of treatment are acceptable or excessive to the patient as a dignified, autonomous person. The moral content of this concept takes into consideration the intrinsic value of human life, the values and beliefs of the person living that life, and the proportionate means by which suffering and life coexist within the moral framework of acceptability. Efforts to maximize good clinical outcomes (including patient satisfaction and quality of life considerations) and minimize harm to the patient take into consideration the proportionate harms and goods that will ultimately lead to a better state for that patient. When pain and suffering, financial burden, spiritual burden, or other forms of harm overpower the promise of treatment, or when death is inevitable in spite of treatment, to continue will only serve to sustain suffering and, therefore, be disproportionate to the needs of the patient. Insisting on the continuance of disproportionate treatment, considering both subjective and objective criteria, violates patient dignity and is therefore unethical.

Futility, as defined in this paper, is not an ethical principle nor a determination of medical outcome, but a dialectic means by which the goods and harms of treatment for a particular patient can be prudentially determined proportionate to one another. Futility in this sense takes into consideration medical probabilities, as well as the values and beliefs that inform the life and moral agency of the patient as well as the provider.

I will argue that the Pellegrino model of futility, as a prudential moral accommodation, still applies and will do so in seven parts by: 1) reviewing the theological and ethical norms of proportionality; 2) differentiating the more limited definition of "biomedical futility"; 3) correlating futility with the complex notion of the patient's good; 4) reaffirming Pellegrino's futility calculus as an ethically appropriate means by which to define those actions that are in the best interest of the patient; 5) arguing that when physician autonomy and patient autonomy conflict every effort should be made to find a mutually acceptable position for the good of the patient; 6) cautioning that futility policies and guidelines should be implemented with caution; and finally, 7) reviewing the moral application of futility.

Proportionality and Respecting Patient Choice

Moral theology offers proportionality as a means by which to judge the moral appropriateness of actions that might otherwise be considered reprehensible. In a utilitarian sense proportionality refers to the appropriateness of a chosen means of action to a desired end. In health care the more familiar sense of proportionality refers to the balancing of goods and harms that result from actions taken (or not taken), and the intention of those actions (or inactions). The second sense is exemplified by the doctrine of double effect, which defends actions as being morally justified if four conditions are met: 1) the act must be morally good or at least indifferent; 2) the intention of the act is to do good; 3) the evil effect of the action is not the means to a good end, which is to say that the evil effect follows the good effect; 4) the proportion of good being done is greater than the evil that results. Double effect is invoked in cases of justified fetal death, withholding and withdrawing treatment, terminal sedation, and allowing patients to die while refusing treatment and pursuing aggressive comfort measures.

Distinguishing disproportionate treatment has also been nuanced to allow the limitation of treatments when they are deemed to be excessively costly, dangerous, painful, difficult, or may otherwise result in unacceptable harm to the patient when weighted against the anticipated benefits of treatment. Proportionality balances evidence based determinants of clinical outcome and prognosis with subjective assessments of patient preference and belief and have supported patients' rights to refuse treatment and to be kept comfortable in the dying process. Distinguishing "proportionate" and "disproportionate" treatment has become more difficult, however.

In the midst of medical technology, skill, and knowledge that is now capable of sustaining life well beyond its natural limits, and so readily available, negative rights of refusal have tended to shift to positive rights to demand treatment. Expectations to treat aggressively are often intense for patients and providers alike. As a result, limiting treatment for patients with advanced illness has become anathema in a medical culture that both promotes patient autonomy and encourages intervention, even when death due to illness or injury is unavoidable. Almost 60% of deaths in this country occur in hospitals, and of those 74% occur after decisions have been made to forgo life-prolonging treatment (7). Eighty-five percent of all patients with cancer admitted to an intensive care unit ultimately die there (8). The internal morality of medicine that obligates the skillful application of medical knowledge and training through diagnostic and therapeutic excellence now admonishes physicians to abhor death and sustain hope of cure, which is one reason that aggressive medical intervention has become so increasingly prevalent at the end of life (9).

The modern day "technological imperative" has also underscored the importance of identifying goals of treatment for patients and encouraged them to express preferences through advance planning and documentation before they become impaired by advancing disease. Multiple barriers have prevented advance planning, however, which is why fewer than 20% of patients admitted to acute and long care facilities have health care directives (10). People often procrastinate because they find the subject of suffering and dying difficult to talk about with family members and their doctors or they find the documents difficult to understand and execute (11). Others believe that health care directives will not change the treatment they will receive, which is not an unfounded concern (12; 13). Many, however, simply do not know what they would want if and when they become seriously ill requiring a decision about limiting or withdrawing treatment. Difficulty in knowing preferences is particularly challenging for vulnerable populations, such as children, the mentally impaired, and patients of advancing age, who cannot or will not participate in discussions about treatment options during times of serious illness (14).

When advance statements of preference do not exist for patients, their families and physicians must often be guided by their own personal beliefs or subjective clues as to what the patient “might want” in the face of devastating illness. The peril of making subjective determinations based on intuition and personal bias is compounded by poorly predictive evidence as to medical outcomes and prognosis. Most end of life decisions regarding limiting treatment therefore tend to occur in the midst of doubt and speculation as to what the patient would probably want or not want done, leading to increasing ambivalence as to whether the patient would consider further treatment to be excessive.

Deciding when and how to stop treatment is not easy due to the plethora of subjective and objective unknowns. Prognosis of disease progression and death are also notoriously inaccurate (15). In addition, patients who can speak for themselves frequently express ambivalence about wanting or not wanting treatment at the end of life (16). Thirdly, expressions of belief and value may not occur at a time when they can be articulated or understood by the family members, the physician, or others involved in the care of the patient, or before the ravages of illness and suffering begin to influence their decisions. If possible, physicians should encourage discussion with patients about end of life care at a time when they and their loved ones are not acutely ill, and when they have the time and capacity to participate effectively. A good time for the physician to do this is in the outpatient setting during routine follow-up visits rather than in the hospital during acute illness.

Physicians likewise have conscientious beliefs that cannot be avoided and should not be ignored. Respect for patient autonomy obligates the physician to prioritize the preferences and welfare of the patient, but professional obligation does not require violating personal or professional moral dictates. Though medical training encourages objectivism and a prudent level of detachment to encourage unbiased clinical judgment, physicians cannot totally buffer themselves from personal feelings while in the midst of ethical dilemmas (17).

A successful and ethically grounded physician-patient relationship presumes respect for autonomy, bolstered by good communication and shared decision-making that requires careful balancing of the values and beliefs of both participants. Futility, therefore, is a calculus prudently undertaken that cannot ethically be performed within a technological vacuum that ignores the moral agency, values, and beliefs of either the patient or the provider.

Biomedical Futility

For centuries physicians, in a paternalistic sense, were trained unilaterally to avoid treatment of untreatable diseases and to avoid harm by useless efforts (18). Decisions about when and how to treat patients who were "beyond hope" were made by physicians, guided by their skill and knowledge, and the benevolent precepts of their profession. Futility for the most part, therefore, was objectively defined as "biomedical futility" by means of a unilateral appraisal of probable clinical outcome made by the physician and based on clinical evidence, experience, and probability.

The acceptability of physician paternalism changed dramatically in the 1970s and 1980s, however, as patients began challenging physicians' rights to make decisions unilaterally. Patients were now demanding, in many cases, that they be the sole determiners of their own fate. Futility began appearing as an ethical concern in the medical literature in the late 1980s. Rapidly advancing developments in medical technology and the sophistication of intensive care units provided the capability of keeping patients alive seemingly indefinitely. In response, patients (as well as many physicians) began voicing concern that they were being kept alive disproportionately (3; 19).

Out of the autonomy movement of the 1970s and 1980s, a demand for greater patient participation and self determination in health care decisions represented a desire to protect and empower patients to refuse unwanted treatment (20). Futility, no longer defined solely by the physician in terms of medical success or failure, was now dependent on, and for the most part dominated by, patient preferences, values, and beliefs.

The ability to delineate between "ordinary" and "extraordinary" treatments has become increasingly difficult. Continued medical advancement and therapeutic success began to blur the ability to define biomedical futility because there has been no agreement in the medical community about underlying precepts that determine futility (21). From 1995 to 1999 the number of articles published in the medical literature dealing with question of futility dwindled dramatically, underscoring the general academic malaise in dealing with a question that could not be answered. Many physicians and theorists have argued that the concept of futility may be indefinable and no longer pertinent in the modern paradigm of health care due to the capacity of modern medicine, the influence of patient preferences, and the expectation by most patients that they be treated (22). Opposing this view is a belief that the very nature of illness and unavoidable death, and the unique nature of the healing relationship, as universal norms have always obligated a consideration of values and beliefs when determining if and when treatment is worthwhile.

Futility in general is the inability to achieve an intended goal or outcome. Biomedical futility more specifically is a clinical judgment that, in light of the patient's current clinical circumstance, it is not physiologically possible for an intervention to achieve its intended and predictable biomedical and therapeutic goals; therefore, the proposed intervention would be medically ineffective. Medically ineffective treatment means that, to a reasonable degree of medical certainty, it is not possible for the proposed intervention to: 1) prevent or reduce the deterioration of the health of an individual; or 2) prevent the impending death of an individual; or 3) effectively or appreciably alter the course of disease. Biomedical futility per se does not take into consideration the beliefs and preferences of the patient, but it cannot avoid being influenced by the beliefs and values of the physician, whose moral precepts are defined by both a personal and professional sense of obligation.

Biomedical futility is a more limited definition of futility. A judgment that, though the intervention has a reasonable possibility of biomedical success, it should not be done because the quality of patient's life would be poor, does not constitute biomedical futility under this definition.

Futility and the Patient's Good

Distinguishing between "proportionate" and "disproportionate" treatment and the notion of medical futility has been conceptually recognized for almost three centuries (18). Human life, though valued and integral to the dignity of each person, is not an absolute good and at some point must be allowed to reach its natural end through death. This means that universal respect for the dignity of each living person also requires respect for the inevitability of death that is a natural component of each person's life. Therefore, seeking the good of each patient translates into respecting death as a natural component of life. The doctrine of proportionality argues that attempts to deny the natural history of disease beyond reasonable means is to deny the good of the patient, which is to say the moral content of that patient's life.

Pellegrino suggests four hierarchical components of the patient's good as a metaethical scheme that can be utilized when reconciling conflicts (23, p. 83-91). The lowest, or least ethically compelling, good is the medical good of the well functioning human person, both physically and psychosocially. At this level the physician has the greatest claim of skill and expertise and for the most part controls opinion regarding objective outcomes and prognosis for treatment. The next level of good is the patient's own assessment of his or her personal good as defined by the patient's moral beliefs and personal preferences. At this level the patient's subjective assessment of treatment goals and preferences are made with the assistance of the physician. In this realm the patient, or their surrogate, has a justified claim of self determination in deciding whether continuing or limiting further treatment is consistent with those goals. This is a subjective realm of preference and may change from day to day as the patient's perceptions and attitude are influenced by knowledge of the situation, symptoms, or emotionality. The third level of good is an objective understanding of the patient as a human person, which can be defined by neither the physician nor the patient. In this level there exists a natural presupposition of good integral to the patient qua person. Pellegrino describes this as a "point of reference to the natural law" giving each person the freedom and right to make his or her own decisions. This is the fundamental and universal understanding of obligation that requires the physician to respect and enhance the patient's autonomy in every way possible. Finally, the highest good is the spiritual good that derives from the fact that humans are created and destined by God, and that life extends beyond the physiologic life that is lived on earth. This good is the integral spiritual life of each person and informs the spiritual needs of the patient that often become increasingly, if not most important to the patient as death nears (24).

Futility in the clinical sense means that the consequences of illness or injury have progressed to a point that a proposed medical intervention can no longer serve the good of the patient. As noted by Pellegrino, good in this context is a complex ideal that encompasses more than desirable biomedical outcomes or patient preferences, but also relates to the fact that death is inevitable and that the patient qua spiritual person should be given the respect and dignity they are due by not attempting to delay death further. Forced suffering in the face of inevitable finitude is disproportionate and ethically unsustainable.

Continued treatment in the presence of futility in this context is to act against the patient's good because it would only serve to prolong suffering, increase expense to the patient and their family, and violate the physician's obligation to respect the patient and to practice medicine prudently.

Futility is not an economic calculus. The concern for utilizing expensive resources for dying patients is undeniably a legitimate organizational and societal concern, but these variables cannot ethically enter into the futility calculus. Economic concern and the distribution of scarce resources may bear legitimate ethical consideration in the board room, but constraining the use of scarce resources in response to concerns for the bottom line, and over the interests of the patient, has no place at the bedside.

The Futility Calculus

Futility is no longer defined solely in medical terms, nor is it a moral principle, but a value laden and prudential assessment of the physician's judgment regarding medical effectiveness tempered by the patient's assessment of benefit and burden (25). A major difficulty with futility determinations is that there are typically multiple stakeholders, often with conflicting opinions as to the degree of patient suffering, and the quality and value of life. Personal value judgments by each stakeholder are unavoidable, including those of the physicians. This complexity of opinion may influence decisions in a direction not necessarily consistent with the patient's stated preferences, even if a health care directive exists or valid surrogate is available. The challenge lies in determining which opinions and values are legitimate and applicable in the futility calculus.

The prudential model of futility incorporates both subjective and objective criteria that can be used in the joint determination of futility by physicians and patients or their surrogates. Unlike the more limited notion of medical futility, the futility calculus is a moral determination of proportionality that strikes a balance between three criteria: effectiveness, benefit, and burden.

Clinical effectiveness is an objective determinant of medical good made by the physician and is evidence based. Effectiveness takes into consideration prognosis and the probability of attaining an intended measurable clinical outcome that will make a difference in morbidity, mortality, or functionality of the patient.

Benefit refers to what the patient perceives as valuable and important to their own welfare or that of others, and is directly related to their personal treatment goals. Benefit centers on the patient's assessment of good insofar as continued treatment, and oftentimes further suffering, is consistent with those beliefs and values that define who they are as a person and the kind of life they want to live. The patient's surrogate, as a valid surrogate, should also represent these values and goals of treatment when the patient can no longer speak for themselves, but only then. While the patient has decision-making capacity, forms of substituted judgment are not valid without the patient's consent or request. In most circumstances the emotionality of the moment makes it very difficult for surrogates, typically family members, to remain objective and selectively represent the patient, especially when they do not agree with the patient's expressed wishes. Personal opinions and beliefs unavoidably conflict in the process of substituted judgment.

Burden is also a subjective assessment made by the patient and may refer to physical, emotional, fiscal, or social costs imposed by treatment. Burden and benefit are not readily quantifiable because of the subjective as well as objective nature of the determination and the outcomes that may or may not be acceptable to the patient. Though the physician may help to inform the burden and benefit variables with objective facts and prognosis, it is the patient, or her surrogate, who makes the final assessment. The ultimate calculus takes into account the proportional relationship of these variables.

> Ordinary treatment is effective, serves some beneficial goal of the patient and/or carries burdens which can be outweighed by effectiveness and benefit. Extraordinary treatment would be futile treatment as determined by the above criteria, that is, ineffective, not consistent with the patient's goals and values, and/or so costly, dangerous, painful, or otherwise so burdensome as to outweigh effectiveness and benefit (25, p. 120).

Futility is therefore not a numerical calculation of facts or an assessment of technological effectiveness, but a means of viewing medical intervention as proportionate to the needs and desires of the patient. The futility calculus should be applied cautiously, however. Utilized too rigorously, a futility determination may ignore the physician's obligation to help the patient live the last days of his or her life as serenely and dignified as possible, even if long-term survival is not possible (25). The fulfillment for the patient and family of sharing one last family gathering may be well worth the discomfort of one more day on the ventilator. End of life care is an opportunity for the physician to step forward with empathy and compassion. Aggressive application of comfort pathways, spiritual support, and palliative care services are critically important in the terminal phase of a patient's life. The physician's caring presence may offer a healing presence well beyond the trappings of modern medicine.

Patient Autonomy vs. Physician Autonomy

Patients and families may demand that "everything be done" even when the treatment in question is no longer medically effective. Ethically, such a demand is not sustainable in the face of biomedical futility because it would force physicians to practice irrational medicine. Respect for patient autonomy dictates that the patient has the right to request and refuse treatment, but the right of autonomy is not an absolute right, and making the request does not obligate the physician to comply if legitimate moral and professional barriers exist for the physician.

Patient autonomy cannot override a physician's conscious moral objection or their professional responsibilities to practice evidence based medicine and uphold standards of care. "Beneficence and autonomy must be mutually re-enforcing if the patient's good is to be served, if the physician's ability to serve that good is not to be compromised, and if the physician's moral claim to autonomy and the integrity of the whole enterprise of medical ethics are to be respected" (26, p. 68). Nevertheless, the question of abandonment often becomes an issue in circumstances where the physician simply cannot, as a moral claim, comply with the patient's request.

Non-abandonment and devotion to the patient's needs is felt by some to be a central precept of physicians, once the patient and physician enter into a relationship. Due to the nature of illness and the obligations of the profession, refusal to respect autonomous decisions of patients or their surrogates, whether to refuse or demand treatment, might be considered abandonment and therefore unethical under this rubric. Quill and Cassel argue that the obligation not to abandon the patient requires physicians to commit themselves to a long term problem solving relationship with patients when there are disagreements (27). Though they do not claim that physicians should violate their own moral standards in the face of that commitment, there is an insinuation that non-abandonment is a primary moral imperative. Such a precept may at some point enable or require exigency to patient demands. A counter argument is that non-abandonment is not a precept, but derives from the nature of the healing relationship. The physician's obligation not to abandon does not super cede the central professional commitment to the interests of the patient, the central moral precepts of the profession, nor the shared moral agency that defines the healing relationship as a covenant of shared trust (28). The emphasis here is on the shared moral agency and covenant of trust between the patient and her physician. Neither party, ethically or morally, can expect the other to extend themselves beyond the moral boundaries of that covenant (29).

Patients are not ethically justified in expecting physicians to provide treatments proven to be medically ineffective, or to do something that the physician believes is morally reprehensible. Physicians as persons are also entitled to respect. The nature of the physician-patient relationship is the moral grounding of medicine and requires that neither the physician nor the patient be empowered to impose their will on the other. When professional and moral commitments become mutually incompatible a respectful separation by safely transferring care of the patient to another provider or health care facility may be necessary. Ultimately, if an accommodation can not be found, a respectful parting of ways may be necessary.

The Peril of Futility Policies

Attempts to standardize criteria for futility through institutional policies and guidelines may offer a means of quality improvement and guidance, but such policies should be crafted and implemented cautiously. Policies and standards may not be consistent between institutions leading to confusion and mistrust by the patient should transfer occur. Futility policies may also depersonalize decision making by removing it from the bedside and the trust relationship that the patient has with her physician. Policies may also imply a legalistic or regulatory tone suggesting the patient's right not only to reject but also to demand treatment, even when the possibility of success or survival is nil (25).

The American Medical Association (AMA) recommends a stepwise process-based approach to organizational futility policies. This process includes several steps to deliberate and resolve conflicts and a final step to enact closure when all alternatives have been exhausted (30). The final step allows discontinuation of the intervention in question if transfer is not possible because no physician or institution can be found to accept the patient in transfer. As an end point in the algorithm this policy appears to support an ultimate unilateral institutional decision to discontinue treatment based on evidence of "unacceptability" (by other physicians and institutions) if there is no physician or institution that will accept transfer. In this process, the final decision is taken out of the hands of the patient and his physician.

There are four steps in the AMA protocol, each step leading to the next if there is irresolvable disagreement: 1) patient (or proxy) and physician collectively define futility, taking into consideration the values and beliefs of the patient; 2) use empirical data to define limits and inform goals of treatment; 3) call in a consultant to facilitate; 4) call in an ethics committee or consultant to facilitate; 5) transfer within the institution; 6) transfer to another institution. In this protocol, orderly and safe transfer of care is suggested at each stage if there is irresolvable disagreement. If transfer is ultimately not possible, because no physician or institution can be found who will comply with the patient's wishes, then the intervention in question "need not be provided," and may be discontinued. The AMA delineates a "fair process" approach that utilizes arbitration to resolve disagreements about what constitutes futility and what is in the patient's best interest.

AMA recognizes the legal and ethical peril should a unilateral decision to discontinue treatment be made against the wishes of the patient or surrogate. Rightfully so, the use of consultants and patient representatives, as well as ethics committees and consult services, are encouraged to assist in the deliberative process when disagreement persists. The peril of institutional futility policies lie in the degree to which institutional means are inserted by degree at each stage of the process. Policies dictating the insertion of other providers, committees, and institutional actions may tend to depersonalize the decision between patients and physicians, ultimately deconstructing the covenantal healing relationship into a contractual arrangement with legal ramifications. Contracts presume failure by one or both parties, there being legal repercussions if certain requirements of the contract are not met—with contract covenant is lost.

Institutional futility policies may also overtly encourage resource allocation, which by insinuation and insertion threatens the trust relationship at the bedside. Multi-institutional policies have been crafted that determine appropriateness or inappropriateness of treatment based on considerations of resource allocation and justify them by arguing that there is an obligation to balance patient autonomy with professional as well as institutional integrity (31). This argument extends further to claim that the prohibition of harming patients, such as forcing unwanted treatments on them, is equivalent ethically to a prohibition of patients and families forcing providers and institutions to undertake treatment that is ineffective. Proponents of this approach firmly ground the ethicality of this policy with an obligation to balance professional and institutional integrity with patient autonomy. Once again, the integrity of the institution and that of the patient cannot be presumed to coincide for mutual benefit. The patient, as the most vulnerable participant in this arrangement is at greatest risk.

Arbitration through ethics consultation and other means can be very useful in circumstances of irreconcilable differences where valued experts and stakeholders are assembled with the unified goal of determining optimal outcomes for the patient, based on good science and valued responses of what kind of life the patient desires. Unavoidably, arbitration at the corporate level, where concern for economics and utilization of resources prevail, will tend to be biased and the moral argument for patient welfare may collapse into a solipsism of institutional interest.

Stewardship of institutional resources is a corporate obligation but may unavoidably result in biased judgments about provisions of seemingly inappropriate treatment for patients. Though institutions have an obligation not to expend resources unreasonably, determinations of resource allocation cannot be made at the bedside by physicians who are primarily responsible for the care and treatment of patients, and who ethically must sustain an unbiased view of actions, or inactions, that are in their patient's best interest.

The Moral Application of Futility

Futility is a means of making prudential clinical judgments about ordinary and extraordinary treatment at the end of life (25). There are multiple extrinsic influences that may influence this judgment—institutional values and economic concern, family interests, the physician's emotional and moral position—making application of futility often difficult. Pellegrino clearly delineates some of the requirements for the morally proper use of futility as a prudential calculus: 1) every determination must be made with full respect to the dignity of the patient as a person; 2) futility must take into account all aspects of the patient's life—mental, spiritual, physical, preferences, and life goals included; 3) futility does not mean abandonment of all treatment or all care-comfort care, symptom relief, and amelioration of suffering must always take priority in the ongoing treatment of the dying patient; spiritual and psychosocial, as well and physical suffering must be addressed; 4) efforts must continue, at an institutional and societal level, to discover genuine cures or treatment for disease now considered incurable; 5) futility determinations cannot be made unilaterally, but as a shared deliberation of objective and subjective information, prudentially considered, jointly by the patient and physician; 6) futility must not be so rigorously applied that it precludes prolongation of life to meet religious obligations, to see family and friends, or to otherwise meet the patient's needs of comfort and fulfillment in the final moments of their living existence.

Caregivers and loved ones are also crucial to the care of patients with chronic illness and become important participants in the discussions about end of life care because patients often defer to them (32). Family members and significant others typically assume the caregiver role while representing the patient to the health care team and participating in the coordination of care. Caregivers' awareness of treatment preferences and what is important to the patient may be unclear, however, if timely discussions have not occurred prior to the loss of decision-making capacity in the patient. Caregivers who are conflicted or unsure may become frustrated and distressed when decisions must be made for their patient. Even when written or verbal healthcare directives exist, they are often difficult to interpret and may not pertain to the clinical circumstances. This often leads to further confusion and ambivalence for caregivers and providers who must ultimately decide for the patient. Family discussions when the patient has sound health and decision making capacity will encourage clarity in directives about treatment goals and the conditions of living that are acceptable or unacceptable to patients as they near death.

Conclusion

Futility is a clinical fact with medical and moral implications. Futility is not a policy or ethical principle, but a value laden moral calculus that provides physicians and other members of the health care team, along with the patient or their surrogate, a means by which to explore the moral permissiveness of withholding or withdrawing treatment. With the modern ability to sustain life well beyond its natural limits, the futility calculus allows the patient and physician to consider both objective and subjective criteria. Balancing medical effectiveness with the patient's perception of benefit and burden allows for a proportional determination of clinical interventions that will most effectively and ethically serve the patient's interests.

Futility must also take into consideration the moral beliefs and professional influences of health care providers as well as those of caregivers and other family members. Futility policies created to address decisions about withholding or withdrawing treatment on the grounds of futility should be crafted and utilized cautiously, recognizing that good clinical outcomes equate to more than biomedical success or economic savings. Futility policies should function as guidelines that will support and encourage the relationships between patients and their providers, avoiding wording that may institutionalize or regiment decisions in such a way that will remove critical and individualized decision-making from the hands of the physician/patient unit. Organizational policies and guidelines that dictate the determination of futility would do well to incorporate an understanding that charity, not utility, is the final principle and ultimate virtue of care for the dying.

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