**Treatments that are 'futile'**

The term 'futile' is used in clinical practice but remains ambiguous and value-laden. A treatment is usually said to be 'futile' in the context of disagreements about whether it should be continued, or ceased. The real disagreement for example between the treating clinician and family is not about whether that treatment is futile, but rather about what goal is appropriate or, put differently, what outcome is worth aiming for.

A consensus definition of medical futility has not been reached in Australian or other jurisdictions. Attempts to define medical futility (i.e. when medical treatments are futile) have all recognised that futility is goal specific. Futility is a relative concept. Whether or not something is futile can only be judged with reference to its goal. Some definitions have included:

- 'Physiological' futility is when the proposed intervention cannot physiologically achieve the desired effect.
- '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.

The NSW Health *Guidelines for End of Life care and decision-making* (March 2005) set out a fair and transparent process by which treatment decisions can be made in such cases that reduce dissent to levels that permit a practical outcome.

Families of patients without decision-making capacity who demand continued treatment in such situations might have unrealistic expectations about what can be achieved. More often though, a family will ask for 'everything to be done' if they are not ready to accept the patient's inevitable death. This situation may be exacerbated when the family are not engaged early in treatment planning prior to the onset of the dying process or where guilt may be associated with fractured or distant relationships within the family.

The efforts of nursing and medical staff, pastoral care workers, social workers or other counsellors should be directed to supporting family members and assisting them to resolve their difficulties in accepting the reality of the patient's impending death. In such circumstances, it is preferable to continue treatment until conflict with relatives is resolved; however time critical situations pose extremely difficult choices and challenges.

The assessment of futility requires that health care practitioners assess the patient's best interests and this invariably requires consultation with the patient's Person Responsible.

**References:**

NSW Health *Guidelines: End of Life Care and Decision Making* (March 2005)
http://www0.health.nsw.gov.au/policies/gl/2005/pdf/GL2005_057.pdf



© - Copyright - New South Wales Ministry of Health for and on behalf of the Crown in right of the State of New South Wales.