Futility and utility

The physician should focus on what can be done, not on what cannot

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"Futility" is a term that has come into prominence in the medical literature over the past two to three decades. This rise has been led primarily by medical ethicists, and has particularly focused on its place in end-of-life discussion.[1] Futility is addressed in this issue of the *MJA* by White and colleagues,[2] who examined its use in a Brisbane hospital by undertaking a survey and interviews with 96 public hospital specialists and trainees from 16 specialties. They found that the term was widely employed, but also that there was some confusion about its meaning and when to invoke it. It is commonly involved in end-of-life care, when medical treatments and interventions no longer seem likely to benefit the patient, either by achieving longer survival or by enhancing their comfort and dignity. A few respondents were confident that available evidence can guide objective decision making in end-of-life situations, but most felt that the uncertainty that attends a patient's terminal days encourages indecision about whether to regard a particular treatment as futile.

Futility is an absolute term; an intervention is either futile or it is not. If it is declared futile, a treatment should be suspended. This finality of the decision that a treatment is futile can disturb both doctor and patient. To the doctor it may bring a sense of failure and disappointment that they have nothing more to offer; the patient may experience despair and abandonment. Both have relied on treatments developed by advanced technologies that held great promise and built high expectations. Neither will wish to fracture a relationship established during the times when therapy achieved effective responses, and this may encourage the doctor to continue a treatment, even one now judged to be futile.

I suggest that, when assessing further management in such situations, "utility" is a more appropriate term than "futility". Utility is not an absolute; it assesses usefulness over a range of applications and opportunities. An action may be partly useful, assisting one aspect of care but not another, or be temporarily useful, pending further consideration. It also has the advantage of positive intent, relating to what can or will be done rather than what should be avoided. In this sense it follows the suggestion made years ago to replace "not for resuscitation" notes with "good palliative care".[3]

Utility is a concept that can attend all phases of patient progress. From the beginning it asks: "What useful outcome can I anticipate? What evidence can I marshal from the literature, from my own experience, and from my patient's past responses and current hopes, to judge whether the action that I propose will be worthwhile?"

A consistent focus on utility has universal relevance to the conduct of any kind of therapy. It will seek to establish the point of balance between hoped for and undesired outcomes, between some good and no good at all. It will apply, for example, to the decision whether to prescribe antibiotics for a sore throat,[4] or whether to request a prostate-specific antigen (PSA) test for a man with urogenital symptoms.[5]

"most palliative care [is] just good medicine and within every doctor's capability"

That balance comes into an urgent focus when considering expensive and intrusive interventions in end-of-life situations. There, in particular, it must be weighed time and again, and shared with both the patient and their attending family.

It is the ethical duty of the physician to acknowledge the finality of "futile", and to work around it by re-directing their efforts towards treatments that have utility. They will maximise the comfort and dignity of the patient and their grieving family, and may well bring an extension of days.[6] To recognise and advise that there is always something that can be done will ease disappointment and maintain the therapeutic relationship. From 25 years of experience, I judge most palliative care to be just good medicine and within every doctor's capability. It calls for kindness, attentiveness, comprehensive assessment of realities, awareness that specialist palliative care resources are available for difficult cases, and a personal confidence in the delivery of comfort care.[7] It needs to be professed by the specialist in the hospital, the family physician serving the patient in the clinic, home or aged care facility, and by the many community care resources that families rely on. It represents a fundamental utility, and is everyone's business.[8]

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