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# **DNR Futility: Medical, Legal, and Ethical Considerations**

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# MEDICAL Consideration



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# FUTILITY

*Latin word- futilis-meaning leaky*

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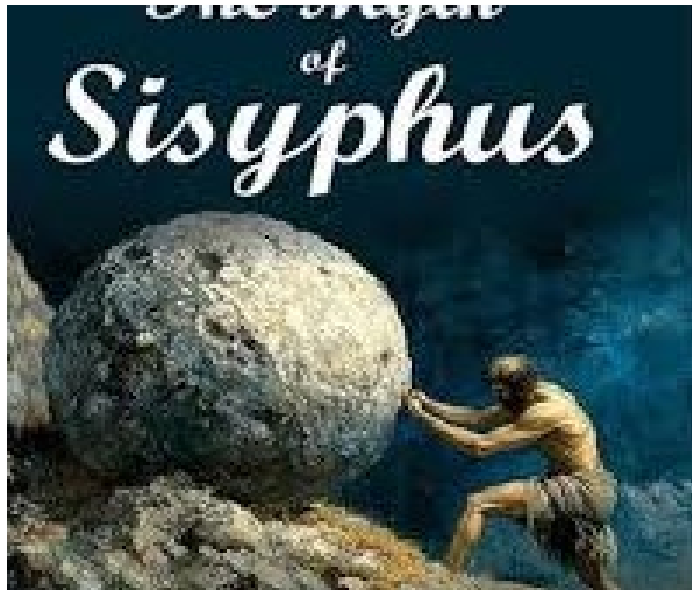
# FUTILITY

- Medical futility is a situation where medical treatment is unlikely to provide any significant benefit to the patient, or when the potential benefits of treatment are outweighed by the potential harms or burdens.
- A medical act is futile if (based on empirical data) the desired outcome, although possible, is **overwhelmingly improbable**.

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# Definition of Futility

- Occurs when CPR cannot be expected to achieve the patient's goals or restore cardiopulmonary function.



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### *The Myth of Sisyphus*

Derived from the Greek myth where Sisyphus is punished to roll a boulder up a hill for eternity, only for it to roll back down.

**Medical judgment:** Physicians are not ethically or legally required to provide treatments that cannot achieve the intended medical outcome.

This is an ancient concept in medicine, with Hippocrates advising physicians not to treat those "overmastered by their disease."

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# Types of Futility

- ***Physiological futility***: The statistical probability of a treatment's success is extremely low (e.g., less than 1%).
- Unlikely to produce any meaningful physiological benefit for patient.
- The treatment fails to achieve its intended physiological effect, such as giving a chemotherapy drug for a stomach ulcer.

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# Types of Futility

- ***Qualitative futility***: The treatment may produce a physiological effect, but the patient's quality of life after the intervention is considered exceedingly poor.
- For example, CPR in a terminally ill patient could restart the heart but leave them with severe, irreversible brain damage.  
(treatment merely preserves permanent unconsciousness and cannot end dependence on ICU care).

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# Types of Futility

- ***Imminent demise futility***: The patient is expected to die in the near future, regardless of treatment.

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# Futility

- ***Futility*** is not rationing; it is patient centered and addresses an intervention that cannot reasonably achieve a desired medical benefit (“**it won’t work**”)
- ***Rationing*** is system centered and involves limiting care based on resource scarcity (“**it cost too much**”) or (“**it is unavailable**”); not making clinical choices based on availability.
- Clinicians should not invoke rationing or resource conversation at the bedside to justify “futility” related decisions.

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# Key Characteristics of Medical Futility

- ***Ineffectiveness:***

- The treatment is unlikely to achieve its intended goal or improve the patient's condition.

- ***Lack of Benefit:***

- The treatment is unlikely to provide any meaningful benefit to the patient, even with a low probability of success.

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# Key Characteristics of Medical Futility

- ***Burdensome:***

- The treatment may impose significant burdens on the patient, such as pain, suffering, or financial costs.

- ***Respect for Patient Values:***

- The decision to withhold futile treatment should be made in accordance with the patient's values and preferences, whenever possible.

# Critique of Futility

- Because there is no agreed upon definition, hidden value judgments may motivate the application of medical futility.
- Undermines patient autonomy
- Quantitative futility erroneously presumes physicians can reliably estimate the probability of treatment success
- Quantitative futility cannot exist with regards to CPR because forgoing it = certain death
- Won't it inevitably be misapplied to the disadvantaged? Disabled?
- Could it lead to clinicians avoiding difficult but important conversations with the patients or surrogates?
- Only the patient/surrogate can determine qualitative/QOL type values. Therefore, qualitative futility should NOT be invoked without discussions with patients or surrogates. Right?



# FUTILITY: CASE STUDY

47-year-old man with widely metastatic (brain, lungs and liver) nasal sinus carcinoma s/p tracheostomy and PEG placement. He was intubated and ventilator dependent after being admitted with acute hypoxemic respiratory failure. Long and complicated (worsening encephalopathy, distributive shock, multiple infections with multidrug resistant organisms, malignant hypercalcemia) ICU tenure. Despite near maximal dose of vasopressors, his blood pressure barely responded and became too tenuous to tolerate CVVH. At a family meeting (spouse is aHCPOA) family is told that no further oncologic treatments would be offered given futility. Comfort focused care recommended. The patient's spouse insisted that the patient remain full code: "I will try everything that I can." "I will not give up!"

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# LEGAL Consideration



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**Legal challenges have generally affirmed the right of physicians to withhold or withdraw futile care, pursuant to due process.**

# DO NOT RESUSCITATE

ALL FIRST RESPONDERS AND EMERGENCY MEDICAL SERVICES PERSONNEL ARE AUTHORIZED TO DEAL WITH THIS OUT-OF-HOSPITAL DNR ORDER.

This request for no resuscitation during a respiratory arrest by \_\_\_\_\_

has been made by the patient or surrogate as follows: \_\_\_\_\_  
I, \_\_\_\_\_, physician below, find this request to be medically inappropriate.

It is understood that this DNR order shall be honored by all EMS First Responders, and other healthcare providers who may be on this patient during a medical emergency.

Patient/surrogate signature: \_\_\_\_\_  
Patient address: \_\_\_\_\_

THE ABOVE NAMED PATIENT IS UNDER THE CARE OF  
Physician Name: \_\_\_\_\_  
Address: \_\_\_\_\_



Before the turn of the 19<sup>th</sup> century, the United States Supreme Court observed that **“no right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.”** Cruzan v. Dir., Mo. Dep’t of Health, 497 U.S. 261, 269 (1990) (quoting Union Pacific R. Co. v. Botsford, 141 U.S. 250, 251 (1891)).

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# Conflict Resolution

*Providers believe CPR is Futile vs Family demands CPR...*

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# Where do you Work?

- VA: “If a competent patient requests that a DNR order not be written or instructs that resuscitative measures should be instituted, no DNR order shall be written.”
- However, physicians are permitted to withhold or stop CPR based on bedside clinical judgment at the time of the arrest
- Interpretation of policies confirmed by NEC and Office of General Counsel
- Froedtert - does have a DNR by Futility policy

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# Legal precedent: 1999 Texas Advance Directives Act (TADA)- revised 2023

- The **1999 Texas Advance Directives Act (TADA)** is a comprehensive law that established guidelines for end-of-life medical decisions, combining previous statutes and introducing new provisions for living wills and witnessing requirements. It aimed to resolve conflicts between families and physicians regarding life-sustaining treatment for terminally or irreversibly ill patients by providing a structured process, including a formal dispute resolution pathway when treatment is deemed medically futile. While proponents believe it prevents morally unjustifiable treatment, some critics argue it may give physicians and institutions too much authority.

# Texas Advance Directive Act (TADA)

- Under the Advanced Directive Act, a physician can refuse to provide life-sustaining treatment so long as they provide the patient with a reasonable amount of time to transfer to another facility or physician that will provide the life-sustaining procedures.
- The Advanced Directive Act provides the patient with procedures giving them a meaningful opportunity to contest the physician's decision.
- Before a physician can stop life-sustaining treatment there is a review by an ethics or medical committee. The patient receives notice of the time and procedures of the committee, can attend the meeting, and can receive a written explanation of the decision the committee reaches. If the committee decides that treatment is futile and the patient or proxy still wants to pursue treatment the facility will assist the patient in transferring to a different facility and continue to provide the life-sustaining treatment for 25 days.

# State Specific Legal Consideration

## Texas and California Legal Process for Futility

1. An “ethics or medical committee” is involved to investigate the appropriateness for futility
2. The patient and surrogate must be given 48 hours notice and be invited to attend the committee meeting
3. A written report of the findings of the meeting must be given to the family
4. Patient or surrogate can seek to be transferred to another physician or facility
5. Patient is liable for any costs incurred in transfer
6. Physician may write orders to withhold or withdraw therapies if no transfer can be guaranteed within 10 days
7. The patient has the right to go to court to extend this period if desired
8. If the family does not seek an extension or the judge fails to grant one, futile treatment may be unilaterally withdrawn with full immunity from civil and criminal prosecution

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# State Specific Legal Consideration

## Maryland and Virginia

- Maryland/Virginia: statutes that exempt a physician from having to provide “ineffective” or “inappropriate” care, but the statutes also require physicians to comply with the wishes of the patient if there is disagreement.

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# State Specific Legal Consideration

## Illinois

- Under Illinois law, a "futile" or Unilateral Do-Not-Resuscitate (UDNR) order is one placed by physicians without patient or surrogate consent, typically when **CPR is deemed physiologically futile.**
- **Respecting Patient Autonomy:** The process must respect the individual's autonomy and decision-making capacity, a fundamental aspect of patient rights in Illinois.
- DNR orders override patient autonomy and shared decision-making when clinicians use unilateral decisions at the end of life, which may contribute to conflict among clinicians, patients, and families.

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# The Illinois Health Care Right of Conscience Act (the Act)

- Currently allows physicians to refuse to provide certain treatments.
- The Act states that providers will not be held liable for refusing to perform treatments that are contrary to their conscience. According to the Act, the conscience includes deeply held moral convictions that typically stem from a belief in God. This language is problematic because it fails to protect physicians who believe that providing futile care violates their ethical duties as physicians.
- In Illinois, the language for the Power of Attorney for Health Care implies that a patient or his proxy can require futile treatments in all situations. This language, when read with the Act, indicates that a patient or their proxy can require futile care even when the physician objects to the procedures on an ethical ground.

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# **State Specific Legal Consideration**

## **Wisconsin**

**Hospitals in Wisconsin (see Froedtert) may have futility policies requiring:**

- a second physician to concur with the primary physician's assessment**
- an ethics committee or designated group to review the case**
- formal notification to the patient or surrogate and an offer for transfer of care**



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# ETHICAL Consideration

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**The Code of Ethics for the American Medical Association regarding Medically Ineffective Interventions states:**

“Physicians should only recommend and provide interventions that are medically appropriate—i.e., scientifically grounded—and that reflect the physician’s considered medical judgment about the risks and likely benefits of available options in light of the patient’s goals for care. Physicians are not required to offer or to provide interventions that, in their best medical judgment, cannot reasonably be expected to yield the intended clinical benefit or achieve agreed-on goals for care. Respecting patient autonomy does not mean that patients should receive specific interventions simply because they (or their surrogates) request them.” (AMA Code of Ethics, Opinion 5.5).

# AMA and NEC Positions on Futility

- Support the concept of medical futility but also recommend
  - **A predefined process**
  - Assessment of the patient's goals should be utilized in the physician's assessment of futility
  - The physician must thoroughly explain and document the reasons for futility
  - If disagreement remains, a review process must occur – i.e. medical assessment by a second physician, assessment by a committee or individual by the facility
  - Patient/surrogate is informed of right to seek transfer
  - Chief of staff must authorize action
  - Legal counsel should be informed and involved

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# Patient autonomy vs Physician integrity

- **Patient autonomy:** The right of a patient (or their designated surrogate) to make personal decisions based on their own beliefs is a cornerstone of medical ethics. They can request or refuse treatment based on their own values.
- **Physician integrity:** Physicians have the right to refuse to provide treatments that violate their professional judgment. This preserves the integrity of the medical profession, as a physician's purpose is to provide treatments that offer a genuine benefit.

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# BIOETHICAL PRINCIPLES

- There are **four bioethical principles** that are generally accepted when analyzing medical situations, such as the use of futile care:
- **autonomy, beneficence, nonmaleficence, and justice**

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# Autonomy

- patient's right to make their own healthcare decisions

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# Beneficence

- requires physicians to promote the well-being of their patients

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# Nonmaleficence

- Nonmaleficence is a complementary imperative to beneficence.
- Beneficence imposes a positive duty on physicians to act in a patient's best interest while nonmaleficence imposes a duty on physicians to avoid causing unnecessary harm.

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# JUSTICE

- Justice refers to the appropriate allocation of scarce resources and the obligation to fairly distribute these resources.

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# Ethical Principals of futility

- A patient's "negative" right to refuse any medical treatment does **NOT** equal a "positive" right to demand a therapy
  - available  $\neq$  obligatory medical therapies
- Physicians are professionally obligated to resist demands for harmful and/or ineffective therapies.
- Even though it's hard to define, ***futility must exist***.
  - Request for a cholecystectomy when there is no evidence of biliary disease.
  - E.g., at some point you call the code, correct?

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# Ethical Principals of futility

- Best medical care = an obligation to offer only treatments that have a reasonable chance of a therapeutic “benefit” for the “patient” as a whole.
  - Not merely to affect some part of the body or simply being able to increase a blood pressure, etc.

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## FUTILITY: CASE STUDY

- *“We will keep him as comfortable as possible and when his heart stops, we will not attempt to restart it. Does this make sense to you?”*
- This framework would (1) send a message that providers will continue to care for the patient
- (2) clarify that the use of CPR is not a treatment that requires deliberation or ownership by the surrogate
- (3) confirm that family members understand that CPR will not be used.



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