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Perspective

Rethinking Futility: Clinician and Family Disagreement in Intensive Care

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ABSTRACT

Medical futility has long served as the concept clinicians reach for when they believe further intensive care cannot benefit a dying patient, yet decades of debate have shown that the term collapses two very different disputes into one word: a narrow factual claim that an intervention cannot achieve its physiological goal, and a much more common values judgment about whether an achievable outcome is worth its burdens.

This perspective traces the field's shift away from 'futility' toward the more honest label 'potentially inappropriate treatment,' and examines why that reframing matters for how clinician-family disagreement in intensive care should be understood and managed.

We review the empirical literature on why these disputes arise -- prognostic misunderstanding, surrogate decision-making burden, and structural discontinuity in ICU staffing -- alongside the procedural, ethics-consultation, and communication-based frameworks proposed to resolve them.

We argue that advance care planning and dispute-resolution procedures each address only part of the problem, and that crisis conditions such as those seen during the COVID-19 pandemic exposed how quickly these frameworks can be strained past their design assumptions.

We conclude that sustained, conflict-anticipating communication earlier in an ICU admission deserves at least as much attention as the procedural machinery invoked once a dispute has already hardened.

Keywords: medical futility; intensive care; surrogate decision-making; clinical ethics consultation; end-of-life communication

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INTRODUCTION

Every intensive care unit eventually produces a version

of the same scene: a clinical team convinced that further intervention cannot help a dying patient, and a family convinced that stopping now would be a

betrayal. The word clinicians have historically reached for in this situation is "futility," and for decades it functioned as though it settled the matter -- if a treatment was futile, the argument went, no one, including the family, had standing to demand it [1]. That confidence has not held up well. Attempts to define futility with any precision kept running into the same problem: whether an intervention counts as futile depends on what outcome one is trying to avoid, and patients, families, and clinicians frequently want different things from the same treatment [2].

The result has been a slow retreat from the language of futility itself. Contemporary critical care ethics increasingly favors the phrase "potentially inappropriate treatment," a deliberately less absolute label that concedes an intervention might still achieve its narrow physiological goal while remaining, in the clinical team's judgment, not worth providing given its burdens and the patient's overall prognosis [3]. This is not merely a semantic substitution. It reframes the disagreement from a factual dispute that medicine can win on its own terms ("this will not work") to a values dispute that medicine cannot resolve unilaterally ("this will work, narrowly, but should we do it"). That reframing is also where most of the interesting and unresolved ethical work in this area now sits.

This review surveys that shift: how the concept of futility has been redefined and increasingly abandoned in favor of "potentially inappropriate treatment," what drives clinician-family disagreement at the bedside, what dispute-resolution and communication frameworks have been proposed and tested, and what the empirical literature says about why these conflicts are so persistent even where structured policies exist. Table 1 summarizes how three influential frameworks differ in the kind of disagreement they are built to resolve, and Figure 1 offers an illustrative comparison of how procedural, communication-based, and legal approaches to these disputes trade off against each other.

FROM FUTILITY TO "POTENTIALLY INAPPROPRIATE": A CONCEPTUAL HISTORY

The classical futility literature tried to split disagreements into two kinds: quantitative futility, where an intervention has essentially no chance of achieving its physiological goal, and qualitative futility, where it might achieve that goal but the resulting quality or duration of life is judged not worth the burden imposed [1]. Quantitative futility was always the easier case to defend ethically, since it is at least in principle an empirical question. Qualitative futility was the harder case, because "worth it" is precisely the kind of judgment that a family, weighing a parent's or child's remaining days against their own understanding of that person's values, might reasonably answer differently than the treating physician.

Early commentary on the concept, some of it dating from the same period the term was first being formalized, warned that "futility" was doing more rhetorical work than analytic work -- it let clinicians describe as a fact what was often a values judgment dressed up in clinical vocabulary [4]. That critique aged well. A multi-society task force convened by five major critical care and pulmonary organizations concluded in 2015 that the term "futile" should be reserved for the narrow quantitative cases and that the much larger and more common category -- treatments a clinician believes are not appropriate given the patient's prognosis and the burdens involved, even though they might achieve a requested physiological effect -- should be called "potentially inappropriate" instead, precisely because that label does not pretend the disagreement is purely factual [3]. A subsequent review of the concept describes this evolution as a move from treating futility as a trump card clinicians could play unilaterally toward treating it as the occasion for a structured, procedural conversation about values [5].

This is not merely an academic distinction. Naming a disagreement as a values conflict rather than a factual one changes who has standing to participate in resolving it, and it changes what a hospital's ethics apparatus is supposed to do when the disagreement will not resolve itself -- adjudicate a clinical fact, or mediate a disagreement about goals [6]. National ethics guidance issued around the same period reached a similar conclusion from a different institutional direction, describing intensive-care treatment decisions near the end of life as properly shared between clinical judgment and the patient's or surrogate's values rather than settled by clinical judgment alone [7].

WHY CLINICIANS AND FAMILIES DISAGREE

The disagreement is rarely about the raw clinical facts once those facts are actually laid out. It is more often about what those facts mean, and family members and clinicians tend to arrive at very different meanings from the same information for reasons that have nothing to do with either side being uninformed or unreasonable. Prognostic communication research has repeatedly found that families of critically ill patients often hold expectations for recovery that diverge sharply from the treating team's stated prognosis, even directly after a conversation both parties believed was clear, and that this misunderstanding is strongly associated with the sort of intractable disagreement that later gets labeled a "futility dispute" [8]. Surrogates are also processing information under conditions -- acute grief, sleep deprivation, the emotional weight of speaking for someone who cannot speak for themselves -- that are simply not conducive to the kind of dispassionate probability-weighting that a well-run family meeting implicitly assumes they can do [9].

Qualitative work with ICU surrogate decision-makers describes the experience as a genuine dilemma rather than a simple task of relaying the patient's known wishes: many surrogates are asked to represent preferences the patient never articulated for the specific situation at hand, and they fill that gap with some combination of guesswork, religious or moral conviction, and a natural reluctance to be the one who authorizes withdrawing care [9]. A recent latent-profile analysis of ICU surrogates found that decision-making self-efficacy -- how confident a surrogate feels in their capacity to make the decision at all -- varies substantially across identifiable subgroups and independently predicts how much conflict a family has with the care team, suggesting that some of what looks like stubborn disagreement is better understood as a surrogate who does not yet feel equipped to decide [10]. Comparative work on surrogates of cancer patients in intensive care describes a similar pattern: decision-making processes are frequently non-linear, revisited repeatedly as new information or new family members enter the conversation, in a way that a single structured meeting is poorly designed to accommodate [11].

Structural features of the ICU compound these dynamics. Conflict-management scholarship in critical care identifies rotating physician coverage, inconsistent messaging across specialties, and the sheer frequency of high-stakes conversations as independent contributors to disagreement, separate from anything about the specific family's psychology [12]. Reviews of what actually helps have converged on the importance of digital and eHealth decision-support tools as one partial answer, though the evidence on their effectiveness at actually reducing conflict, as opposed to improving comprehension, remains mixed [13].

DISPUTE-RESOLUTION FRAMEWORKS AND THEIR LIMITS

The 2015 multi-society statement did not stop at renaming the phenomenon; it proposed a stepwise procedural approach for potentially inappropriate treatment requests, moving from negotiation and voluntary transfer of care, through internal ethics consultation, and only as a last resort to an institutional determination that treatment may be withheld even over family objection, with unilateral withdrawal reserved for a narrow category of interventions the statement calls "futile" in the strict quantitative sense [3]. Subsequent commentary examining how family-clinician disputes actually play out under "contested definitions of futility" has argued that the procedural approach works reasonably well precisely because it does not require the parties to agree on what futility means -- it only requires them to follow a shared process for resolving disagreement when it occurs [14].

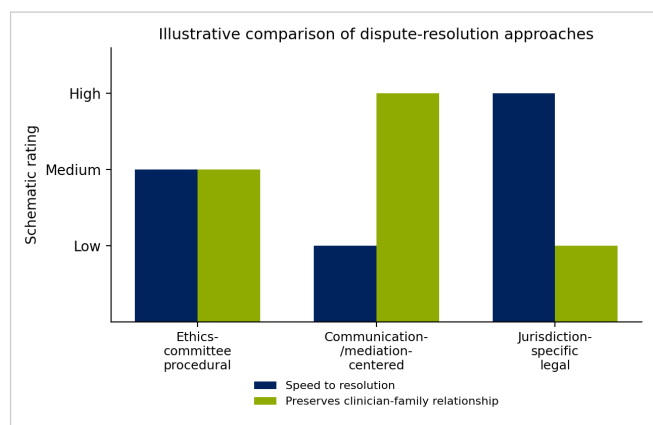
disputes -- purely procedural/ethics-committee frameworks, communication-and-mediation-centered approaches, and jurisdiction-specific legal mechanisms -- differ in what they assume about the source of the conflict and therefore in what they try to fix. Ethics consultation services, when used, appear to function less as adjudicators handing down a verdict and more as a structured space where the underlying disagreement can be named and, often, partially dissolved once each side better understands the other's reasoning; case series from specialized settings such as neuro-oncology describe consultations resolving a meaningful share of disputes without recourse to any formal institutional determination at all [15]. That said, ethics consultation is a scarce resource unevenly distributed across institutions, and a framework that depends on it will systematically underserve hospitals that cannot staff it.

Table 1. Three broad approaches to clinician-family disagreement in intensive care, compared by what each assumes is the source of conflict and what it is designed to fix.

Approach	Assumed source of conflict	What it targets	Main limitation
Ethics-committee / procedural (e.g. multi-society statement)	Impasse after negotiation has failed	A stepwise process ending in an institutional determination	Depends on ethics-consultation capacity, unevenly available across institutions
Communication- and mediation-centered	Prognostic misunderstanding and unmet emotional needs	Earlier, clearer conversation to prevent disagreement from hardening	Improves understanding and satisfaction more reliably than it resolves standing conflict
Jurisdiction-specific legal mechanisms	Irreconcilable disagreement requiring external authority	A binding external resolution when internal process fails	Slow, adversarial, and unevenly available across jurisdictions

Table 1 lays out how three broad approaches to these

Figure 1. Schematic, illustrative comparison of how the three dispute-resolution approaches in Table 1 trade off between speed to resolution and preservation of the clinician-family relationship (Low/Medium/High ratings reflect the authors' synthesis of the reviewed literature, not measurements from a single empirical study).



A parallel body of work has focused less on adjudicating disagreement after it hardens and more on preventing it through better communication earlier in the admission. A 2022 Cochrane review of interventions for interpersonal communication about end-of-life care between clinicians and patients or families found consistent, if modest, evidence that structured communication training and communication aids improve family understanding and satisfaction, though the review was more cautious about claims that these interventions reliably reduce conflict itself, as opposed to the family's experience of the process [16]. A scoping review focused specifically on interventions supporting families of patients who die in intensive care similarly found that most existing interventions target information provision and emotional support rather than conflict resolution directly, leaving a gap between what the literature has studied and what clinicians actually need when disagreement has already emerged [17]. Broader guidance on family-centered critical care, updated in 2024, explicitly folds conflict prevention into its recommendations rather than treating it as a separate problem, on the premise that most disputes are more tractable if caught during the early days of an ICU admission than after positions have hardened [18].

ADVANCE CARE PLANNING AND THE LIMITS OF PRIOR PREPARATION

One obvious response to clinician-family disagreement is to prevent the disagreement from arising in the first place, by ensuring the patient's own preferences were documented and discussed before the crisis. Advance care planning is frequently proposed on exactly this logic, and a recent narrative review describes real progress in normalizing these conversations across serious illness generally [19]. But advance care planning's protective effect in the acute ICU setting is more limited than this logic suggests, for a structural reason: most advance directives are written in general terms ("no heroic measures," "comfort care if no

reasonable chance of recovery") that still require a surrogate and a clinical team to jointly interpret how those terms apply to the specific, often unanticipated clinical situation at hand. Work on end-of-life decision-making in acute stroke, a condition whose trajectory is notoriously difficult to predict in the first days, illustrates how even a documented directive leaves substantial interpretive work, and therefore substantial room for disagreement, to the people at the bedside [20].

This matters for how the field should calibrate its expectations. Advance care planning reduces the raw frequency of some disputes -- particularly ones rooted purely in not knowing what the patient would have wanted -- but it does not eliminate the harder category of disagreement, where the family's genuine understanding of the patient's wishes and the clinical team's genuine judgment about medical appropriateness are both defensible and still point in different directions.

CRISIS CONDITIONS AND THE LIMITS OF ANY FRAMEWORK

The frameworks described above were largely developed and tested under ordinary operating conditions, and the COVID-19 pandemic exposed how much they depend on those conditions holding. Analyses of ICU triage during periods of extreme resource scarcity have described a distinct ethical failure mode in which denial -- by families, and at times by institutions under public pressure -- functioned as a barrier to honest prognostic conversation that ordinary dispute-resolution procedures were not designed to address, because the usual assumption of adequate time, staffing, and continuity of care no longer held [21]. Addressing futility disputes under crisis conditions, a 2022 practical framework argues, requires the same underlying principles -- clear communication, procedural fairness, appropriate use of ethics consultation -- but compressed into a much shorter timeline and applied by clinicians who are themselves under acute strain, which changes what counts as a realistic standard for how these conversations should go [22]. Palliative care integration into ICU practice, addressed directly in reviews of the legal and ethical dimensions of end-of-life care in critical care settings, has been proposed as one way to build resilience into the process, embedding conflict-anticipating communication skills into everyday ICU practice rather than treating them as a specialized response reserved for when disagreement has already surfaced [23].

CONCLUSION

The retreat from "futility" toward "potentially inappropriate treatment" was not a cosmetic change in vocabulary. It was an acknowledgment that most of what clinicians and families actually disagree about at the end of life in intensive care is not a settled clinical

fact but a genuinely contested judgment about which burdens are worth which chances of benefit, and about whose account of the patient's values should govern that judgment. Procedural frameworks built around this newer, more honest framing have given institutions a workable process for cases that reach an impasse, and ethics consultation services appear genuinely useful where they exist and are used early. But the empirical literature on why these disputes arise in the first place -- prognostic misunderstanding, surrogate decision-making burden, structural discontinuity in ICU staffing, and the practical limits of advance directives once a specific crisis actually arrives -- points toward prevention through sustained communication as at least as important as any dispute-resolution mechanism applied after the fact. Crisis conditions like those seen during the pandemic showed how quickly even well-designed frameworks can be strained past what they were built for, which argues for building communication capacity, and not just procedural machinery, into ordinary ICU practice well before the next such strain arrives.

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Conflict of Interest

The authors declare no conflicts of interest relevant to this work.

Author Contributions

Ines Kraus conceived the review, coordinated the literature synthesis, and drafted the initial manuscript. Agnieszka Rossi performed the literature review on surrogate decision-making and communication interventions and critically revised the manuscript. Claire Whitmore contributed the sections on dispute-resolution frameworks and crisis-condition ethics and provided final approval of the submitted version. All authors read and approved the final manuscript.

Ethics Statement

As a literature review synthesizing previously published, publicly available research and policy analysis, this article did not involve new data collection from human participants and did not require institutional ethics committee approval.

Data Availability

No new data were generated or analyzed for this review. All sources discussed are cited in the reference list and are publicly available through their respective

publishers.

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