

... some real medical "limits" prove to be truly elastic around expansions and contractions of wealth and insurance status.

By Kate Scannell, MD, Editor
 Commentary by Stephen C Henry, MD

Medical Futility

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While our therapeutic armamentarium and scope of medical practice have broadened considerably since the time of the ancient Greeks, both the concept of medical "futility" and the argument about who defines it continue to be debated at a level that resonates with earlier articulations by Plato and Hippocrates. Both men argued that medical practitioners should recognize limits in applying their art and science. Relevant to modern-day discussions about health care resource allocation, they also maintained that it was a defining characteristic of a good physician to withhold therapeutic interventions when limits had been reached, regardless of the patient's ability to pay for them. Hippocrates advised his students "to refuse to treat those who are overmastered by their diseases, realizing that in such cases medicine is powerless."

Modern-day society continues to struggle with the old arguments about whether medical limits should be set, if the medical profession should decide when treatments are futile, and whether the scope of medical care that one actually receives should depend upon one's personal wealth. This macroscopic struggle also occurs in an era of rapidly expanding, life-sustaining technologies (like organ transplants and advances in cardiopulmonary life support) and, indeed, even life-creating capabilities (like cloning and stem cell work). These developments stretch the notions of both "medical limits" and "futility."

Meanwhile, on a clinical or "microscopic" level, patients and medical personnel routinely decide through highly individualized negotiations at the bedside which limits they will observe according to which treatment goals they choose to pursue, framing as "futile" whatever lies outside those limits. In these circumstances, "medical limits" and "futility" will be defined in highly individualized and diverse ways.

But what happens—as in the case that follows—when doctors and patients and/or their surrogates disagree about the meaning of futility and the appropriateness of limit setting? And while it has been pointed out that discussions about medical futility should be carefully separated from those concerning health care rationing and resource allocation, like Hippocrates, others have asked for a moral accounting that reflects the reality of the relationship between the macroscopic and microscopic dimensions of health care as it is actually made available.

While few people would openly advocate that medical care should be linked to a person's wealth or capacity to affect the distribution of health care resources, reality shows us that this often pertains. Health care access is unevenly distributed, and, as such, some real medical "limits" prove to be truly elastic around expansions and contractions of wealth and insurance status. Consequently, the meaning of futility can bend around the real variations of differently set limits.

As one example, we can consider limits and futility in the setting of antiviral therapies for AIDS

patients. There are factors other than democratic biological considerations that determine who gets treated, who faces which limit, and for whom treatment becomes defined as futile. While in theory easily separable, notions of "limits" and "futility" become linked to social and economic factors when they become the embodied notions that they must become in the reality of clinical settings. The strain of this embodiment taxes us intellectually, and it disturbs idealized notions of ourselves as a just and compassionate society.

CASE Who Decides the Futility of Medical Care?

Mr Longsley is an 80-year-old, widowed, demented nursing home resident who takes multiple medications for his chronic lung disease and congestive heart failure. He arrives in the emergency room for the fifth time in six months with acute-on-chronic respiratory failure due to yet another aspiration pneumonia. When the lone emergency room physician suggests that a repeated intubation and ICU admission would prove to be futile, Maura, the patient's daughter and only kin, disagrees. She asserts that her father enjoys his life in the nursing home, and that his life remains meaningful to her.

The physician asks Maura if she truly believes that her father would want to undergo the repeated trauma of intubation, especially when the underlying neurological problem causing his recurrent aspirations was unlikely to improve? He performed Mr Longsley's last two intubations, and he believes that they caused

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him terrible distress. There are no advance planning documents, and Mr Longsley hasn't spoken since his most recent stroke one year ago. Still, Maura contends that her father conveys his unambiguous desires to her through nonverbal cues. She insists that he wishes for aggressive treatment as needed to sustain his life, but that he does not want a permanent tracheostomy. A decision about intubation must be made within minutes of Mr Longsley's imminent death.

Should the physician honor the daughter's request?

What are the doctor's professional obligations to himself, the patient, and the daughter?

What is "futile" treatment?

Who decides?

What should the physician do in an urgent situation when he firmly believes that the treatment he is asked to authorize violates his conscience? ♦

Additional information, including complementary and/or dissenting views on this issue can be accessed on the Kaiser Permanente Intranet by visiting *The Permanente Journal* Web site (www.kp.org/permanentejournal); click on this article in the Table of Contents and then click on the link to Ethics Rounds.

Commentary

By Stephen C Henry, MD, Chair, Ethics Committee, KPMC San Jose/Santa Teresa, CA

Wouldn't it be nice if we could just have "the big one" and die quickly without having bothered much with the medical profession? Less than 10% of us will die in this fashion. It is much more likely that we will enter a situation like Mr Longsley's in which the period preceding our death is characterized by a slow decline punctuated by periodic crises, any one of which could cause death unless aggressively treated. Because our commonly held ideas suggest that death is either sudden or follows a relatively short and steady progression to a predictable death, we are not well prepared as physicians or patients to deal with recurring life-threatening episodes. We do not have a good model to help us decide which of these episodes ought to be the last, so that the unpleasantness of aggressive treatment could be avoided.

The physician in this case appears to be invoking futility as a reason not to initiate treatment. He seems to define futility as, "This stuff hurts; he's demented, and he'll just be back next month no matter." Maura disagrees, contending that, despite his disabilities, her father has a meaningful life and should continue to receive aggressive treatment.

Dictionaries define "futile" as completely ineffective, serving no useful purpose. Since people differ in their assessments of utility or purpose, claims of medical futility are, inherently, value judgments.

Several approaches have attempted to refine the definition. One approach is quantitative, posing that if an

intervention has failed more than 99% of the time, it is deemed to be futile. Other standards include strict physiologic criteria, established community standards and/or professional criteria, or institutional standards based on policy. Others define futile treatment as that which would only prolong dying. More recently, several authors suggest that futility should be decided on a case-by-case basis after engaging in appropriate discourse among the involved parties. They caution against using the term "futility" as a shortcut to avoid meaningful and sometimes difficult discussions.¹

Some institutions have developed futility or "non-beneficial treatment" policies based on various criteria. For example, in the model policy adopted by the Santa Clara (CA) County Medical Association Ethics Committee, non-beneficial treatment is defined as: "a treatment that has not or will not be reasonably expected to meet a goal wished by the patient; a treatment whose burden or harm outweighs any expected benefit; a treatment that is ineffective or harmful." In addition, non-beneficial treatment includes the following: provision of treatment when a patient or surrogate requests only comfort care; treatment to a patient in an irreversible coma or persistent vegetative state; treatment to patients permanently dependent on intensive care to sustain life; and cardiopulmonary resuscitation in patients with severe irreversible dementia.²

The Education for Physicians on End-of-Life Care



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(EPEC) project of the American Medical Association outlines a six-step "Due Process Approach to Futility Situations." These steps are: 1) attempt to negotiate understanding among the involved parties in advance to preempt conflict; 2) negotiate solutions to disagreements; 3) if disagreement persists, suggest the participation of other consultants, colleagues, or the institutional ethics committee; 4) if the review supports the patient's position and the physician remains unpersuaded, arrange transfer of care to another physician; 5) if the review supports the physician's position and the patient/surrogate remains unpersuaded, consider transfer to another institution; 6) if it is not possible to transfer the patient to another physician or institution, the treatment need not be offered, but only after a diligent search is conducted. If institutional policy allows for this last option, there should be open disclosure of this policy to all parties involved. Great care should be taken not to join a futility policy with utilization management considerations. Nor should a futility policy be used to blatantly override patients' or surrogates' autonomy.^{3,4}

So what should our physician do? I believe that he should proceed with intubation and should initiate life-saving treatment along with measures to relieve Mr Longsley's discomfort with the procedures. Mr Longsley does not meet the criteria set out above for conditions that would suggest that treatment is futile. It does seem that the physician is using futility as a substitute for discussion, especially when there seems to be disagreement about Mr Longsley's ability to communicate and express his own wishes. Aggressive treatment is not likely to be physiologi-

cally futile: we seem to be quite good at treating aspiration pneumonia with respiratory insufficiency. The protocols and policies regarding non-beneficial care all require substantive discussion over time; a crisis situation in the Emergency Department is hardly the time in which to make a decision that cannot be reversed.

We do not have a good way of prospectively managing patients whose course is characterized by these recurring crises amidst a steady decline. Neurologically compromised patients, along with those who have exacerbations of chronic lung disease or congestive heart failure, often present challenging clinical and moral decisions about when the "last" crisis episode should occur. It is usually after a failure of intensive therapy that we make a decision to forgo further treatment. Incorporating discussions regarding these issues into long-term care as part of advance care planning could help avert potential conflict in the acute care setting. ❖

References

1. Medical Futility in End-of-Life Care: Report of the Council on Ethical and Judicial Affairs. JAMA. 1999;281:937-41.
2. Prototype for a Non-Beneficial Treatment Policy. Santa Clara County Medical Association, 1997.
3. Rivin AU. Futile Care Policy, Lessons learned from three year's experience in a community hospital. West J Med. 1997;166:389-93.
4. Education for Physicians on End-of-Life Care (EPEC), American Medical Association, 1999. See Module 7: Goals of Care; Module 8: Sudden Illness; and Module 9: Medical Futility.

Believe in a Child

To believe in a child is to believe in the future.
 Through their aspirations they will save the world.
 With their combined knowledge the turbulent seas of hate and injustice will be calmed.

Henry James, 1843-1916, American author