The Ethics of Medical Futility

Raul de Velasco, MD, FACP
Director, Clinical Ethics
University of Miami Ethics Programs
Chair, Baptist Health Bioethics Committee
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What is Medical Futility?
Who decides?

A treatment that will not achieve its goal

Physician
Patient
Payer

HEALTH SYSTEM

Patient
Physician
Payer

SOCIETY

A debate between means and ends
Medical Futility
A Cross-National Study

edited by
Alireza Bagheri
forward by
Daniel Callahan

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Is this Futility?

- A treatment that will achieve its goal <1% of the time with **minimal risks** to the patient and at **small cost**.
- A treatment that will achieve its goal <1% of the time with **very high risks** to the patient and at **small cost**.
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The Tensions

1. Inevitability of death and illness
2. The limitations of scientific medicine
3. The ends of medicine
4. The availability of resources
5. Socio-religious and cultural Issues
6. Conflict of interests
What is Futility?

Physiological Futility

A treatment that will never achieve its goal

• Treatment with antibiotics of an uncomplicated viral infection (physiological futility)
• Any treatment to improve cognition in a brain dead patient or in Permanent Vegetative State
What is not Futility?

Normative Futility

A treatment that may achieve its goal

- Any treatment to maintain life in a brain dead patient or in Permanent Vegetative State

It is not futility because it will achieve the goals of those who define life as mere existence, but is futility for those who define human life as the one where there is cognition.
Case #1

• 33 year old woman mother of 3 children who refuses blood transfusions based on her religious beliefs develops acute leukemia, a disease which with aggressive treatment which, will certainly include blood transfusions and a bone marrow transplant, could have a good outcome. Several oncologists have refused her as a patient because they consider that any treatment, without blood transfusions, is futile.

• She found an oncologist in one of our hospitals who will treat her without blood transfusions.

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- Physician
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HEALTH SYSTEM

SOCIETY

A debate between means and ends
Do patients have the right to refuse treatment?

In the USA there is a legal and ethical consensus that any capacitated patient has the right to refuse any recommended medical treatment even if this leads to the patient’s death.
Case #2

• 55 year old man with a mental age of 3-4 years, who has been taken care of by a dedicated niece, was brought to the hospital in respiratory distress secondary to a pseudomonas pneumonia requiring intubation and mechanical ventilation. The niece has no medical training but claims to be a believer of natural remedies and is suspicious of ‘scientific medicine’.

• The infectious disease specialist starts her on levofloxacin.

• After finding out the new treatment the niece became outraged and demanded it to be discontinued and that as treatment for the pneumonia the patient be started on 5 grams of vitamin C intravenously and pro-biotics via the tube feeding.

• The administrative nurse ordered the nurses not to administer the antibiotic. Her decision was based on the principle of the autonomy of the patient reflected on the niece’s deciding for the patient.
Case #2 cont...

- An ethics consult was requested by a staff nurse. The recommendation of the ethics consultants was for the antibiotic to be restated immediately and to go to court if not.
- The hospital asked for an emergency court hearing where the judge supported the ethics consultants recommendations.
- The pneumonia improved, the patient was eventually removed from the ventilator and discharged.
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A debate between means and ends
Do Patients Have The Right To Demand Treatment That Appears Futile?

In the USA a physician is not under any legal obligation to provide a treatment he/she does not believe is in the patient’s best interest. But that does not mean that the physician can provide treatment even if he believes the treatment will not achieve the goals the patient seeks if certain conditions are met...
Evaluating a Patient’s Request for a Life Prolonging Procedure

1. Is there a chance that the treatment is effective in achieving the patient’s goal?
2. How does the physician evaluate the benefit-harm ratio of the treatment?
3. Does the patient assess the situation realistically?
4. Patient still favors treatment, denial?
5. Discuss cost of care

Conditions Required for Acceptable Administration of Futile Treatment

1. It is provided in the context of an ongoing patient/physician relation
2. The physician is competent to provide the treatment
3. No other competent physician is available
4. Some equitable funding is available
5. The treatment is fundamental to preserve life or manage pain etc...
What Physicians May Do?

A Survey

Would you recommend life sustaining treatment which you consider to be futile?

Yes: 23.6%
No: 37.0%
It depends: 39.4%
I'm afraid there's really very little I can do.

“I’m afraid there is really very little I can do”
Framework for the Process of Discussing Futility

• Preventative -ethics –approach
  – Physicians should share with patients/families the patient’s management and prognosis early on in the course of hospitalization, before the clinical situation calls for futility like discussions
  – Focus on the patient’s expressed wishes (advance directives written or verbal)
  – Joint decision-making (assessing & aligning goals – patient’s & treatment team)
  – Negotiation of disagreements (involve ethics committee)
A Process to Consider

A process without the word

• Every patient admitted to the ICU
  1. Gets full intensive treatment including CPR unless a restrictive level of care is in place (DNR)
  2. If incapacitated, a legal decision maker is identified following the hierarchy established by State law.
  3. If capacitated the patient is encouraged to fill an advance directive, either one or both.
   ▪ Living Will
   ▪ Health Surrogate
A Process to Consider...
A process without the word

Every patient admitted to the ICU is assigned to a level of end of life care

4. The levels of care orders are written in a pre printed order form and filled after empathically discussing with the patient/decision maker the indications and rational for the treatment. One of the levels is chosen sharing with the patient or decision maker that recommendations may change. This is documented in the chart.

I. If patient is on a respirator and the heart stops, should it be resuscitated?
II. No cardiopulmonary resuscitation in case of cardiac or pulmonary arrest
III. Level II is unchanged but withholding certain invasive treatments and procedures such as dialysis, surgery etc. is decided
IV. All life prolonging procedures are withheld or withdrawn except for those that provide comfort.

5. If patient is on a ventilator, or other active life prolonging procedures, before they are removed, the patient if capitcitated, or the decision maker if not, has to fill and sign the withdrawal form.
Rationale for the Process

• It encourages empathic communication with the family and clear instructions to the nursing staff.

• It allows time to adapt to the ever changing medical condition of the patient, adjusting the level, intensity and goals of care, in a manner which is appropriate to the patient’s condition.

• It empowers the family bringing respect for their views, cultural background and perspectives.
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Futility, ‘no treatment is going to maintain a life meaningful to me’ of course exists, we are all going to die. But the implication of the term when used by a physician to support the unilateral decision to withdraw treatment is fraught with many practical and conceptual problems. A better way is to have the decision maker involved, empathically, and from the beginning in the process of care so that when the physician arrives to the clinical judgment, through *phronesis*, that further life prolonging treatments is useless those who are part of the process will also be there.
Thoughts?
Questions?