The Appropriate Use of Medical Futility in Treatment Decisions at the End of Life

LEARNING OBJECTIVES: 1. Assess medical futility in relation to treatment goals near the end of life. 2. Recognize the ethical application of unilateral Do-Not-Resuscitate orders.

CASE INFORMATION: A 47-year-old female with metastatic colon cancer presented from home with fever, rigors and weakness. Her examination and work-up was consistent with cholangitis and treatment was initiated with antibiotics and placement of a percutaneous biliary drain. In spite of a short interval of improvement, the patient's hospital course was further complicated by bilateral hydrenephrosis and acute renal failure secondary to tumor progression. Anuria and massive volume overload ensued and the patient developed hypoxic respiratory failure requiring intubation and transfer to the ICU. Sepsis was evolving secondary to fungemia and bladder invasion by the tumor necessitated frequent blood transfusions. The patient was unresponsive and unable to interact with her family or doctors. Given the patient's advanced disease and multi-organ system failure, the ICU team expressed to the family that in this tragic situation, future escalation of care would be medically futile. The family maintained that the patient had openly communicated her desire to pursue all life-sustaining therapy and to retain a full code status. A younger brother of the patient had a prolonged survival with lymphoma in the setting of aggressive therapies and the patient's own sister had survived ovarian cancer. The patient's family members were united in their view that the patient had wished to maintain life as long as possible, declaring that their faith has led them to hope for a miracle despite the grim prognosis given by the medical team. To withhold treatment was seen by the family as a betrayal of the promise they had made to respect her wishes. Despite the families' preferences for aggressive care, the ICU team decided that CPR was medically futile, and would only increase suffering without prolonging survival. The patient was administratively made DNR and eight days later she died. The local police were then contacted by family who believed the patient had suffered a wrongful death.

IMPLICATIONS/DISCUSSION: The concept of futility is often used to withhold or withdraw care from patients with advanced disease. Medical futility is defined as a clinical action that cannot achieve a stated goal for an individual patient. However, quantitative criteria by which futility can be measured do not exist. Futility is ultimately a value-based determination which cannot be made without first establishing concrete treatment goals. As highlighted in the above scenario, if the patient's goal is to maintain physiologic life, then CPR may not be a futile intervention.

A unilateral decision to withhold life-sustaining measures based on the principle of futility risks imposing religious or subjective values regarding the end-of-life onto patients and their families. Such actions may foster a culture of paternalism and present an opportunity for misuse as providers may try to avoid difficult discussions. Yet, to require that physicians deliver care believed to be ineffective or misguided poses a threat to one's professional integrity and violates the principle of first doing no harm. Medical futility should not be used as a justification for rejecting a patient or proxy's preferences, but can be used as a framework for discussing goals of care. A hierarchy in which physician autonomy should take precedence over patients' self-determination does not exist. When a resolution cannot be reached, hospital ethics teams should be consulted to facilitate mediation and to advocate for both patients and physicians. Ultimately,
medical futility is not grounds for unilateral treatment decisions. Case law, state statutes, and professional codes of ethics will be used as examples to exhibit these points.