

# How to determine when treatment is futile

## And who gets to decide



Terry Jones, MD, is an attending physician at a hospital in central Minnesota. Two weeks ago, an 86-year-old male patient was admitted to the hospital after contracting influenza at the nursing home where he has lived for the past three years. The patient's condition improved with significant intervention, but he remains on oxygen and continues to cough. His appetite has deteriorated and he has lost significant weight since being admitted. Jones expected to discharge the patient, but the nursing home refuses to take him back. To make matters worse, Jones did a routine chest x-ray on the patient that revealed a loculated abscess in the lower lobe of the patient's right lung. Medical staff have recommended that the abscess be surgically removed but the patient is a very high-risk surgery candidate. Without surgery, the patient likely will not improve. The patient's family has indicated that the medical staff should do whatever the patient wishes. Is this a case of medical futility? If so, how should futility be defined and communicated to the patient and his family?

### ***Whether treatment is futile depends on the patient, the intervention and the timing***

Generally, the term “medical futility” applies when, based on medical data and professional experience, a treating health-care provider determines that an intervention is no longer beneficial. Medical futility does not apply to treatments globally; it refers to a particular intervention at a particular time, for a specific patient.

Key in these situations are the ethical principles of autonomy, beneficence and non-maleficence; we must come from the framework of our patient and not our own, the decision must be in the best interest of the patient and there should be no harm. Although age should not be a specific factor, it can change the effectiveness of certain treatments and may affect the personal goals of a patient. What is considered futile for our patient in their 80s and nearer the end of their natural life may not be the same as for a patient in their 30s with much of their life still ahead.

The goal of medicine is to help the sick. Although the ethical requirement to respect patient autonomy entitles a patient to choose from among medically acceptable treatment options (or to reject all options), it does not entitle patients to receive whatever treatments they ask for. Physicians have no obligation to offer treatments that do not benefit patients; they should offer treatments that are consistent with professional standards of care that confer benefit to the patient. However, determining which interventions are beneficial to a patient can be difficult, and there is some subjectivity to any given situation, so a patient or surrogate

might see an intervention as beneficial while their physician does not.

Futility is best adjudicated by determining the clinical benefit—or lack of benefit—of an intervention and how it affects the goals of care. This rule should be uniformly applied whether a patient is young or old, poor or rich, learned or with limited education. Given this subjectivity, it is helpful to involve the expertise and experience of the medical team in reaching a determination.

Determining whether a medical treatment is futile basically comes down to deciding whether it passes the test of beneficence: that is, will this treatment be in the patient's “best interest”? The test of beneficence is complex because determining whether a medical treatment is beneficial or burdensome, proportionate or disproportionate, appropriate or inappropriate, involves value judgments by both the patient and the physician.

This brings us back to our case, which is that of a high-risk situation for a complex elderly patient who, one way or another, is approaching the end of their life. Informed consent with shared decision-making is one ethical process for approaching this situation. What facts can we discuss with this patient to help with their decision? Helpful information could include:

- What is the expected survival rate for an 86-year-old patient over the next one to five years?
- What is the survival rate for complex lung surgery for a patient in their late 80s with multiple comorbidities?
- Are there less risky options that could be discussed?
- What are the personal goals of our patient for his remaining years?

For a 30-year-old patient, a 2 percent chance of survival may seem worth going for. For our frail 86-year-old patient, a chance of less than 20 percent of leaving the hospital alive after surgery is not futile but it may not be as attractive as other options, such as being discharged to another location with home health or hospice care, in order to have as much quality time as possible with family and friends.

And that comes back to our definition of futile: “Is the situation and proposed treatment useless?”

I guess if the chance is “not zero,” it depends. MM

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### **Communication is the key to making an ethical decision**

**A**lthough the term “futility” appears to be straightforward, it is actually quite complex. As with most ethical challenges, there are many perspectives to be considered.

The “four-quadrant” approach to medical ethics analyzes a patient’s situation through questions about clinical considerations, patient preferences, quality of life and other factors. Clinical considerations (weighing beneficence and non-maleficence) and patient preferences (respecting autonomy) are generally straightforward.

Quality of life is the *patient’s* definition of quality, regardless of the ideas of the physician or institution providing care. Other factors can include a wide variety of considerations including equity and fairness, family issues, religious codes and cultural norms and more. By engaging deeply with the patient as a whole person, the treatment team will most likely be able to align the medical issues with the patient’s preferences and definition of quality.

Potential ethical dilemmas occur multiple times daily, but usually do not develop into quandaries because there is an alignment of variables in the four quadrants. Challenges arise when there is a lack of alignment. The key linking factor, which is substantially within the physician’s control, is communication.

As George Bernard Shaw said, “The single biggest problem in communication is the illusion that it has taken place.” At the Center for Advancing Serious Illness Communication, we believe that supporting a formalized approach to conducting and archiving conversations about serious illness and end-of-life considerations allows for earlier, more frequent and better discussions. The Center provides techniques, training and tools to support clinicians in the conduct of patient-centered and robust conversations that will empower the patients, families and future treatment teams—well ahead of any crisis. The principal benefit is allowing the reliable expression of the patient’s explicit values and the reliable delivery of goal-concordant care. When communication is planned with this in mind, medical futility decisions can often be preempted by keeping the four quadrants in alignment.

In this case, the medical intervention, drainage of the abscess, is technically feasible and may ease some of the patient’s symp-

oms, but with some procedural risk. Recovery may be arduous and not fully restorative. The key is that this competent patient retains his decision-making authority. MM

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## Center for Advancing Serious Illness Communication

The Center for Advancing Serious Illness Communication (CASIC) is a new joint initiative of the Minnesota Medical Association and the Minnesota Hospital Association. Its goal is to prepare clinicians and healthcare organizations to engage every patient experiencing a serious illness in meaningful discussion about their diagnosis, prognosis and care choices. Funded by Blue



### The Center for Advancing Serious Illness Communication

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Cross Blue Shield of Minnesota, the Center began work early this year and is developing tools and resources to improve communication practices.

CASIC offers training for clinicians, and guidance for incorporating new communication skills into everyday practice. It CASIC also helps sites and systems develop best practices for serious illness communication, including patient identification,

documentation practices, internal resources needed, information on coding and reimbursement, development of workflows and dashboards and more as needed.

There are not enough palliative care specialists to meet the needs of patients, so it is critical that all clinicians have some level of familiarity and comfort with conducting these types of conversations. There are evidence-based tools and training that CASIC can help provide to help hone the skills needed to have a meaningful discussion.

The benefits of learning about serious illness communication include:

- Studies have shown that satisfaction improves for patients, their loved ones and their caregivers and clinicians when these conversations happen.
- Having a serious illness program at your site also impacts staff wellness.
- COVID-19 has highlighted the need for a different communication style, making both healthcare professionals and the general public more aware of its importance.

To learn more, please visit [www.AdvancingSIC.org](http://www.AdvancingSIC.org) or contact Executive Director Karen Peterson at [kpeterson@mnmed.org](mailto:kpeterson@mnmed.org).