Medical Futility in the ICU

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June 3, 2010
You're fifty seven years old. I'd like to get that down a bit.
...not for the good it will do, but that nothing may be left undone on the margin of the impossible.

T.S. Eliot
Outline

I. Background on Futility
II. The Challenges of Futility
III. Practical Recommendations
I. Ethics, History & the Law

- Patient’s right to decide about withdrawing/withholding treatment
- Surrogate’s right to decide if necessary
- Physician’s professional, legal, ethical right to withhold/withdraw futile treatment

American Medical Association Code of Ethics, June 1994
Ethics of Futility

- Oldest principles (fiduciary relationship)
  - Beneficence
  - Non-maleficence
- Newer principles
  - Autonomy
  - Justice
History of Patient Autonomy

1976: Quinlan decision (right to die, refuse LSMT)
1990: Cruzan decision reaffirms
1990: Patient Self-Determination Act
1990: 50% of ICU deaths involve wd/wh (Smedira)
1997: 77% (Prendergast)
1997: AMA, SCCM, ATS, ACCP
   - ethical and legal propriety of limiting unwanted treatment, necessity of pall care
History of Futility

• **430s BC**: Hippocrates “refusal to treat those who are overmastered by their diseases, realizing that in such cases medicine is powerless”

• **1976**: CPR policies “out of the closet”  

• **1980s**: Futility to justify unilateral decisions

• **1987**: Blackhall: CPR not universal  

• **1990**: Futility defined as none in the last 100  
Futility as Practiced

Commonly used

- 34% MDs continue treatment against patient/surrogate wishes
- 83% withhold, 82% withdraw unilaterally interventions judged to be futile

Definitions of Futility

• Physiologic futility
• Quantitative futility
• Qualitative futility
II. The Challenges of Futility

- Achieving consensus
- Determining & Following patient preferences
- Estimating prognosis
- Evaluating benefit
- Physician fears
- Balancing individuals & society: resource allocation
“It may be wrong, but it’s how I feel.”
Achieving Consensus

• Cannot agree on the definition
• In the eye of the beholder, subjective/personal:
  a) is unlikely to be of any benefit to a particular patient in a particular medical situation
  b) will not achieve the patient’s intended goals

Determining & Following Patient Preference

- AD may not be present
- AD may not be specific enough
- Surrogates may be unrealistic
  - No improved mortality
  - Increased cost

Patient Preferences cont.

AD may not influence care

Support Trial

But… may be that is changing

Estimating Prognosis

• We’re poor at prognosticating

• RNs and MDs don’t agree on futility
  – Docs and RNs not agree in 63% of dying
  – Cannot predict QOL
  – RNs more pessimistic, more correct


• APACHE less effective at individual level

Evaluating Benefit

• May be unexpected
  – 47% hospital survival for >70yo >30 day in ICU

• Cannot figure out others’ quality of life

• Experiences change patient’s preferences
  – eg CPR
Experience Changes Preferences
Assessment of CPR by Survivors

- 55% Want CPR Again
- 42% Not Want CPR Again
- 3% Ambivalent
Physician Fears of Litigation

- Generally, courts don’t want to be involved
- Only 11 states have laws requiring treatment with no time limit to allow transfer
- Almost always support physician decisions
  - Especially Ex Post (duty, breach, direct causation, damages)
  - Ex Ante sometimes injunctions are ordered to allow transfer
Individual and Society: Resource Allocation

- Public policy should not be determined at the bedside
- However, when will rationing of health care enter the debate?

III. Practical Recommendations

1. Don’t talk about futility
2. Give it time
3. Focus on the relationship
4. Offer excellent communication
5. Rely on policies
6. Call in help
7. Support each other
1. Don’t Talk about Futility

- We don’t agree on what it is
- We don’t agree on how to evaluate the benefit of interventions
- We can misuse the futility argument
  - 33% used the argument of Quantitative Futility but estimated the chance of survival to be 0-75%
  - 18% used the argument of Qualitative Futility, but only 1/3 discussed QOL

Curtis, JAMA, 1995
American Medical Association Code of Ethics, June 1994
Focus on goals of care

– specific
– achievable
– benefits and burdens

2. Give it Time

- Talk AND listen more
- Allows for conflict resolution
  - 57% of patients and surrogates agreed immediately to a physician's recommendation to limit intensive care
  - 90% agreed within 5 days
  

- Therapeutic trials
3. Focus on the Relationship

- Fiduciary
  
  “Physician commits himself to the patient's best interests but retains a role in defining those interests.”
  
  TJ Prendergast

- “Assent” rather than consent
## Enhanced Models of the Patient-Physician Relationship

<table>
<thead>
<tr>
<th>Type of Autonomy</th>
<th>Goals</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>None (Parentalism)</td>
<td>MD</td>
<td>MD</td>
</tr>
<tr>
<td>Simple (Consumerism)</td>
<td>Patient</td>
<td>Patient</td>
</tr>
<tr>
<td>Enhanced (Professionalism)</td>
<td>Patient</td>
<td>MD</td>
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</tbody>
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### Types of Patient-Physician Relationships
- Paternalistic
- Deliberative (includes shared decision-making)
“All medical care flows through the relationship between physician and patient, and the spoken word is the most important tool in medicine.”

Eric Cassell
4. Offer Excellent Communication

- Communication… not Criteria or Committees

- Communication as a skill
  - “Effective communication about end-of-life care requires training, practice, and supervision, as well as planning and preparation”

- Communication improves outcomes
  - Family meeting and EOLC as opportunities for improved care
Family Communication Needs

(1) A clinician willing to talk
(2) Timely and clear information
   - Information needs are paramount
     - Prognostic information > decision-making
     - Control over timing

Steinhauser, J Pain Sx Mgmt. 2001;22:727
Butow, Support Care Cancer, 2002

(3) A clinician able to listen
“Stanley, we need to talk, so please don’t interrupt.”
Listening Outcomes

• Seattle ICU study
  – 51 family meetings
  – Average length 32 minutes (7-74 minute range)
  – 29% vs 71%

• Increased proportion of family speech associated with
  – Increased satisfaction
  – Less reported conflict

McDonagh, Crit Care Med, 2004
Evidence for Family Meeting

Bereavement brochure and communication guidelines (VALUE)

- Valuing what the family members said
- Acknowledging their emotions
- Listening
- Understanding the patient as a person through asking questions
- Eliciting questions from the family members.

- 30 vs 20 min meetings: 14 vs 5 min family talk
- Decreased caregiver depression, anxiety and PTSD at 2 months

Lautrette, NEJM, 2007
5. Rely on Policies if Necessary

- Community-based consensus standards
- Hospital futility policies
  - Due process: negotiation, shared decision-making, ethics committee
  - Transfer to another MD (if institutional review supports proxy) or another institution (if supports MD)
  - If no transfer possible, no intervention

AMA Code of Ethics, 1994
6. Get Help: Ethics Committees & Palliative Care Services

- Help is usually… Communication
- Proven benefits to Ethics Committee
  - No difference in mortality
  - Decreased ICU/hospital LOS among dying
- Proven benefits to Palliative Care Consultation
  - No difference in mortality
  - Pain & Non-pain symptoms
  - Patient/family satisfaction
  - ICU length of stay & Cost
7. Support Each Other

- Crisis of conscience: Adults
  - 47% of MDs and RNs
  - 70% of house officers

- Crises of conscience: Peds
  - 54% of house officers
  - 48% of critical care nurses
  - 38% of critical care attending physicians

- Spend the time to achieve consensus, or at least offer support and mutual respect