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PALLIATIVE CARE CASE OF THE MONTH

When is Medical Care Futile?

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Case: Mrs. X was an elderly woman who had been hospitalized for pneumonia. She was intermittently confused during the admission but was stable for discharge to an inpatient rehabilitation facility after one week. Soon after admission, she suffered a large gastrointestinal bleed with aspiration and was transferred to the medical intensive care unit (ICU).

The patient had been very vigorous and active (e.g., she golfed three times a week) prior to the admission. She did, however, have a large lung mass diagnosed several months previously. The mass was a probable lung cancer that the patient did not want worked up.

Mrs. X lived with her husband and adult daughter. She was predeceased by a son who died 30 years prior in a motor vehicle accident. Mrs. X had been devastated by her son's death and had stated for years that she hoped to die on the same date as her son as a way of "being with him."

Upon transfer to the intensive care unit, the patient was alert, oriented, and coherent. She was intubated for respiratory distress. Over 24 hours she became septic and needed increased ventilatory and blood pressure support.

Palliative care was consulted because, prior to intubation, the patient had told the ICU team that she wanted to be intubated because she wanted to "to die on the same date that my son died." The date of her son's death was roughly 20 days after admission to the ICU. The ICU intensivist thought the patient should be extubated because "It is ridiculous to try to keep a woman with lung cancer and sepsis alive so she can die on a certain date. This treatment is futile."

The palliative care team spoke to the patient within 24 hours of admission. Although intubated, she made clear that her wishes were as stated above. She also understood that it was unlikely that she would live 20 days in her current condition. Within hours she was unresponsive but comfortable. The palliative care team then spoke to the husband and daughter. They were very knowledgeable and appropriate. For example, they said "we know she won't make it out of here. If she dies before the date, it is God's will." However, even though survival was unlikely, they very strongly wanted the medical team at least to *try* to respect Mrs. X's wish.

Within 24 hours, the intensivist was pressing the family to "make a decision" (i.e., withdraw care). A meeting was set up with the intensivist, palliative care team, and the family. It was agreed upon that the patient was competent when she stated her wish. It was also agreed upon that the patient would be very unlikely to survive the 20 days needed for her to realize her goal. Finally, there was consensus between the medical staff that continuing care would delay death by a few days at most.

Confronted with a request to continue care for 20 days—which was clearly unreasonable and had virtually no chance of success—the intensivist saw no reason to continue life-supporting therapy at all. The idea that making the attempt might have value for its own sake, as a gesture of respect for the family's desire to honor Mrs. X's wishes, did not initially appear to him as a valid reason to continue. After discussion with the palliative care team and the family, however, all parties involved agreed to wait a few days to see if the patient might improve enough to reach her goal.

Mrs. X died three days later.

Discussion: Futility is an ancient concept. Hippocrates stated that physicians should "refuse to treat those who are overmastered by their disease, realizing that in such cases medicine is powerless."[1] Improvements in technology, the trend towards patient empowerment, and the spiraling costs of health care have all contributed to making the concept of futility more relevant than ever.[2]

For the purposes of this discussion, futility is defined as a clinical action serving no useful purpose *in attaining a specified goal*.[3] While all parties in this case knew that survival was unlikely, treatments that are medically ineffective may still provide perceived benefits (e.g., allowing closure) to patients and families. The primary goal of this patient and family was not to have Mrs. X live as long as possible. Rather, it was important to them that the medical team make *an attempt* for the patient to die on an important date.

Was the care Mrs. X received in the last three days of her life "futile"? The ICU team's respect for the Mrs. X's wishes, rather than withdrawing care, allowed the family to respect their loved one's wish. This was of great psychological and spiritual benefit to the family.

References:

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