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Medical Futility

Withholding or Withdrawing Life-Sustaining Interventions

- Mamak Tahmasebi MD
- Associate Professor/TUMS
- Gynecologist/ Palliative Medicine Fellowship

Definition of the terms

- The word "***futility***" is derived from the Latin ***futilis***, which means leaky.
- ***Withholding*** LST involves a deliberate decision not to initiate treatment aimed at prolonging life.
- ***Withdrawing*** LST involves removing an intervention with the same expectation.

History of Medical Futility Debate

Hippocrates admonished, the physician must "refuse to treat those who are overmastered by their disease, realizing that in such cases medicine is powerless".

Plato similarly recognized, "For those whose lives are always in a state of inner sickness did not attempt to prescribe a regime to make their life a prolonged misery … A life with preoccupation with illness and neglect of work is not worth living".

History of Medical Futility Debate

- The contemporary debate over medical futility began in the late 1980s
- *Cardiopulmonary resuscitation* (CPR) was invented in 1960
- During the remainder of the decade, other life-sustaining treatments were introduced, including both positive pressure *mechanical ventilation* and *extracorporeal life support*.
- At the end of the 1960s, most US hospitals had *ICUs*.

History of Medical Futility Debate

- At the same time that life-sustaining treatment was being introduced, major *social changes* were occurring.
- Most notably, the field of *bioethics* emerged in the 1960s' context of **civil rights** and **women's rights**.
- In contrast to the *paternalism* of the previous era, bioethics adopted a patient-centered framework that defined medical ethics in terms of *individual rights and* ***patient autonomy***.
- One important manifestation of this emphasis was the doctrine of ***informed consent***.

Examples of Futile or Inappropriate Interventions

- CPR
- Artificial Hydration/ Nutrition
- Dialysis
- Ventilator support
- Antibiotic therapy
- Diagnostic interventions (e.g. Lab tests, CT-Scan, MRI,…)
- …

Case Presentation…

- A 48-year-old woman with metastatic rectal cancer. Widespread liver mets., carcinomatous peritonitis, and with pelvic recurrence.
- The patient presented to the ED with progressive jaundice and due to extensive hepatic involvement, no further therapeutic intervention is considered feasible.
- Following pelvic recurrence, she developed bilateral hydronephrosis, she underwent bilateral nephrostomy tube placement…

Consent to Treatment

- The principle of Autonomy requires that patients make an informed consent (or refusal) of treatment.
- Their wishes are valid provided the process is
  - Informed
  - Understood
  - Voluntary

How Much Information?

- Healthcare professionals are often faced with the dilemmas of disclosure e.g.:
  - Families who say “don’t tell!”
  - Patients who don’t want to know
  - Even when patients want to know, we have difficulty dealing with bad news

If the Patient is Incapacitated?

- Refer to advance directives if available
- Otherwise, decision on interventions could be made on basis of:
  - Substituted judgement
  - “Best interest” of the patient
- In order to do this, we need an understanding of patient’s preferences and priorities, what is important to them and what they would like to avoid.

How to Make a Decision?

- Estimate Prognosis
- Compassionate Communication
- Clarify values and goals
- Explain Burdens

1. Obtain a second medical opinion.
2. Give notice of the process to surrogates.
3. Obtain review by an interdisciplinary hospital committee.
4. Offer surrogates the opportunity to transfer the patient to an alternate institution.
5. Implement the decision of the resolution process.

Conclusion:

- Futility does not mean the same thing to different people
- Personal values and beliefs, cultural and religious background, may affect decision making
- Sensitive communication, clarity of goals and outcomes and team approach in working with family, are important

This is the Ethical Art of **“Letting Die”**