FUTILE TREATMENTS IN INTENSIVE CARE. CONTROVERSIES AROUND FACTS AND TERMS

Ioana Grigoraș*, Emilia Pătrășcanu*, Irina Ristescu*

Abstract
Futile treatment in intensive care patients is a hot topic around the world and a matter of intense debate and controversy. The consequences of such treatments are three-fold: the prolongation of patient’s suffering without long-term benefits, missed opportunities for other patients and high cost-benefit ratio in terms of resource allocation. By the same time a lot of controversies arise. Who should decide futility of treatment? What does futility really mean? Which should be the prevailing factor in the decision of futility: patient’s interest or optimization of cost-benefit ratio in resource allocation? Is the term futile care appropriate? Is the term futility appropriate? In order to avoid futility judgments to be applied arbitrarily, the medical community should set explicit standards and procedures that support the ethic of care in terminally ill patients.

Keywords: futility, ethics, intensive care, end of life

Corresponding Author - Emilia Pătrășcanu: emiliap79@yahoo.ro

*UMF “Gr. T. Popa” Iasi, Romania, Anesthesia and Intensive Care Department, Regional Institute of Oncology, Iasi, Romania
In October 2013 a study performed by Thanh N Huyhn et al. at The Los Angeles University California was presented at the Chest Congress in Chicago, Illinois, USA and elicited vivid debate. It is no wonder that the study presentation resulted in contradictory opinions between congress attendees, but amazingly penetrated also into the public, non-medical media. Why this public interest for a medical study, which does not present any innovative treatment for an incurable disease? The explanation is twofold. On one side, the worldwide economic crisis makes resource allocation a hot topic. Intensive Care Units (ICU) costs were estimated to be in 1995 1% of USA GDP (1). On the other hand in USA approximately one third of patients are treated in ICU at the end of life (2).

The aforementioned study entitled "The opportunity cost of futile treatment in the intensive care unit" aimed to evaluate how care was delayed and/or compromised for other patients due to futile treatment in ICU (3). For a three months period on a daily basis, ICU physicians from 5 ICUs in an academic hospital were asked to evaluate if patient received futile or probably futile treatment. The criteria to establish treatment futility were as follows: imminent death, permanently unconscious patient, no chance of survival outside intensive care, and treatment cannot achieve goals. 6916 evaluations were performed by 36 ICU physicians on 1136 patients. Of these patients, 904 (80%) were never perceived to be receiving futile treatment, 98 (8.6%) were perceived as receiving probably futile treatment, 123 (11%) were perceived as receiving futile treatment (4). The patients with futile treatment received 464 days of treatment perceived to be futile in critical care, accounting for 6.7% of all assessed patient days. Eighty-four of the 123 patients perceived as receiving futile treatment died before hospital discharge and 20 within 6 months of ICU care (6-month mortality rate of 85%), with survivors remaining in severely compromised health states. The cost of futile treatment in critical care was estimated at $2.6 million (4). There were 72 (15.7%) unit-days when the unit was full and had at least one patient receiving futile treatment (3).

The study evaluates for the first time missed opportunities - delayed admissions from the emergency departments (ED) and delays in transfers from other hospitals for other patients due to futile treatment in ICU, a topic perceived and discussed for a long time. The results are quite striking. Among 463 admissions from the ED, 33 patients were held more than 4 hours when the ICU was full and housed a patient receiving futile treatment. 22 patients were transferred after more than one day of being determined to need ICU care, and 37 transfer requests were cancelled after waiting that long. In particular, 9 patients spent a total of 16 days waiting to be transferred from other hospitals and 15 patients cancelled their transfer request during this type of situation. In addition, two patients died while awaiting transfer (3). The authors also found that a full unit was less likely to admit a patient receiving futile treatment than another with available beds (38% vs 68%; P <.0001) (3). "As physicians, consciously or unconsciously, we do try to reduce futile care when the ICU is full," explained dr. Huyhn at the
The obvious consequence would be the transfer of patients with futile treatment to palliative care and ICU admission of patients with better chances of survival. It seems to be fair and ethical, and nonetheless... it is from here that controversies begin.

Who should decide on the futility of medical intervention? The physician, who can best evaluate treatment options and chances to achieve goals? But this is physician-centered medicine, a wrong approach, which should be abandoned. The patient in ICU is usually unable to decide and an informed family is no guarantee of reasonable decisions. Many times family members have a sense of guilt and responsibility to their loved ones, they want everything done, and many times they do not understand what it means. The recommended approach at the end of life decisions for ICU patients is the active involvement of physicians, nurses, family members and, if rarely possible, patients. This was one of the limits of the Huyhn study, which lead to critical comments: only ICU doctors and moreover only one ICU physician were asked to evaluate the treatment futility.

But why giving up fight when chances of survival are scarce? Which chance of success is too small to be considered useful? ICU physicians are used to obstinately treat patients with very low chances of survival, for instance trauma or multiple organ failure patients. Can the chronic health status make the difference? Or can the expected quality of life make a difference? And who can decide what for another person acceptable quality of life may represent? Another limit of the Huyhn study is the fact that after six months 15% patients, who received futile treatment in ICU, were still alive! Criticism was raised about the accuracy of perceived treatment futility (5). Probably the shared decision making may avoid doubtful judgments. Nevertheless, Thanh noted that the study focused on "utility, not mortality" (5).

On the other hand, medicine should be delivered on a “first come, first served” basis. If a patient is already in ICU under treatment it seems unethical to act in favor of another patient. But on a battle field (and, believe me, an ICU is a battle field!) casualties are not treated on a “first come, first served” basis, but a triage is done in order to maximize survival chances. Why not do the same in ICUs?

In technology-driven ICUs aggressive life-prolonging treatments too commonly appear to offer no medical benefit to patients. Many of these patients needlessly suffer, but doctors continue to provide same treatments. There are many reasons doctors provide futile care. Physicians fear that futility judgments will be disputed by families, challenged in litigation or commented in the media.

Vocabulary is extremely important in medicine. The term futility was challenged during the congress discussions. Clinicians in the audience said they were hesitant to use the word "futile" because it "can do us a disservice" when talking to patient families."Futility gets us into trouble. Physician-centric is an artful way of saying it," said another audience member. Instead, he suggested that the treatment should be regarded as inappropriate (7). Also the term of futile care is challenged. „Care is never futile. Everyone wants and deserves...
care until their final breath. ICU, disease-directed, and invasive interventions are often futile in terms of achieving the goal of restoration of health or a tolerable quality of life” (7).

What does futile treatment really mean? Discussions about futility may be compared with walking on a minefield. Most patients want to live with a self-defined acceptable quality of life. But nearly all physicians, even those who oppose futility policies, will agree that there are limits to physicians’ professional obligations to provide requested treatment. On the other hand, to set the ethical standards not to apply specific medical interventions is a difficult task. Futility can only be defined in terms of the intended goal. The usefulness of medical interventions should be discussed in terms of outcomes, not processes. What do they hope for? Is it achievable? What are the alternatives and their likely outcomes? (7, 8). The definition of these standards should incorporate quantitative (probability of success) and qualitative (quality of life) elements (6). The ability of the medicine to define explicit, ethically valid standards for medical futility may solve this debate and offer the framework for addressing the care needs of dying patients without resorting to futile treatments (6). In addition, such ethical standards may set the difference between futility (a patient-centered determination of no benefit) and rationing (a means of distributing resources that have offer benefits) (6).

This study leaves many important questions unanswered. But it highlights an issue we often prefer to ignore: hospitals do over-treat patients who are near death. In order to avoid futility judgments to be applied arbitrarily, the medical community should set explicit standards and procedures that support the ethic of care in terminally ill patients.

References