When Doctors and Patients Disagree About Medical Futility

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Medical and technological advances mean that cancer patients have more treatment options today than ever before, even patients with advanced disease. This wide range of available options can unfortunately lead to the postponement of complex end-of-life decisions. In addition, physicians and patients may come to different conclusions about which treatments are best to pursue, and when the goals of care should shift to supportive measures only. This vignette illustrates several factors that may help physicians determine when additional treatment is medically futile, and what physicians should do when patients want to pursue medically futile treatments instead of exploring more appropriate care options. In addition, this vignette addresses techniques physicians use to open lines of communication with patients about end-of-life care.

Vignette

The patient is a 53-year-old married mother of three teenagers, diagnosed with stage III ovarian cancer. After an optimal debulking procedure, she was treated with paclitaxel and carboplatin for 3 cycles and did well for two years. She then relapsed and was treated with multiple chemotherapy regimens, experiencing considerable toxicity with each regimen. The patient now has progressive disease with worsening performance status and arrives at the emergency room in respiratory distress. She is admitted to the hospital with sepsis and a bowel obstruction. Her condition is stabilized in the intensive care unit and she is transferred to an inpatient floor. The oncologist approaches the patient and husband about the goals of care going forward. Both want to continue chemotherapy treatments, understanding the toxicity involved and the limited benefit to be achieved. The patient's husband is quite adamant about continuing chemotherapy treatment, and the patient states that she is willing to "take her chances." The medical oncologist believes that a transition to palliative care is the appropriate course of care at this time.

Discussion

When Is a Treatment Medically Futile?

There is no uniform definition for medical futility. State laws rarely define medically futile or ineffective care.[1] The American Medical Association (AMA) guidelines describe medically futile treatments as those having "no reasonable chance of benefiting [the] patient"[2] but fall short of defining what the word "reasonable" means in this context. The American Thoracic Society says a treatment is medically futile when it is highly unlikely to result in meaningful survival.[3] The Society for Critical Care Medicine and others say that physicians must be certain that an intervention will fail to accomplish its intended goal before concluding that the intervention would be medically futile.[4,5]

Without a clear definition, many doctors provide treatments that may, ultimately, be medically futile. Studies show that many cancer patients receive chemotherapy in the last 12, 3, and 1 month of life, and that receiving chemotherapy is correlated with a delay in referral to hospice.[6] Doctors cite expectations for treatment by patients and family members, uncertainty about a patient's prognosis, and legal pressure as reasons for providing treatments they think are medically futile.[7] Uncertainty of prognosis can be a significant issue in chemotherapy, where treatment outcomes are difficult to predict.

The AMA Code of Ethics says physicians have an affirmative obligation to transition a patient to palliative care when other treatments have no reasonable chance of providing benefit.[2] The AMA Code is in concert with ASCO's policy statement on Cancer Care During the Last Phase of Life, which reminds physicians that "at the moment in the course of an illness when treatments directed at the cure of cancer are no longer likely to benefit the patient. . . it is essential to modify the management goals and offer care that is directed at symptom management, and that is sensitive to a patient's spiritual and psychological need."[8] Providing medically futile treatment is not consistent with this professional ethic.

In the absence of a clearly articulated standard, physicians may find it helpful to consider the following points when determining if a treatment is medically futile:

The goal of the treatment in question. Physicians may want to clarify with patients the rationale for different treatment options. For example, is the treatment intended to improve the patient's quality of life through symptom relief or tumor reduction?

The likelihood of achieving treatment goal(s). Patients may have different measures for futility than health care providers. Terminally ill cancer patients are shown to be less concerned with adverse effects than their health care providers, and are more likely to choose continued chemotherapy rather than palliative care for less—or even no—expected benefit.[9]

The risks, costs, and benefits to the patient of pursuing the intervention, compared with alternatives. Risk-benefit assessment can include physical and psychological adverse effects, as well as financial considerations and insurance coverage.

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The individual needs of the patient. Physicians may consider how patients measure quality of life, their understanding of their prognoses,[9] and whether they are aware that palliative care is an option.[9] Recent research shows that patients who overestimate their likelihood of long-term survival are more likely to experience a death perceived as "bad" (eg, in the ICU, intubated, with resuscitation, or as a result of adverse effects of treatment). Physicians are encouraged to open a dialogue with their patients to gain a better sense of their patients' personal, emotional, and spiritual needs. Physicians should also assess the role a patient's family members may play in the patient's decision-making process.[9]

In this vignette, the risk-benefit ratio of the desired chemotherapy regimen is unfavorable. This treatment offers virtually no chance of clinical benefit, prolonged survival, or quality of life–improvement, and will result in significant toxicity that the physician sees as undue harm. Based on these factors, it is reasonable to conclude that the treatment will be medically futile. However, a confident assessment of medical futility is only the starting point for the physician in this case. The physician's most important challenge is to communicate with the patient (and the patient's family, if appropriate) about transitioning to care primarily intended to manage her symptoms at the end of life.

Communicating With Patients About End-of-Life Care

It is important for physicians to discuss the concepts of medical futility and palliative care early in the physician-patient relationship. Physicians should be straightforward and plainspoken about medical futility and the goals of palliative care to ensure that patients are well-informed. Studies show that a physician who is not direct can inadvertently mislead a patient about his or her prognosis and treatment goals.[8,9]

Furthermore, early and ongoing communication allows physicians to understand patients' individual needs and perspectives, which are important factors in making joint treatment decisions. Ongoing discussions also give patients the opportunity to weigh their options in advance. This prevents surprises when the time comes for treatment goals to shift from primarily curative to primarily palliative, which allows the patient to make better end-of-life decisions. If physicians and patients disagree on matters of medical futility, early conversations also give the patient time to find a physician who shares his or her views. Physicians should be sure to inform patients of any institutional policies that dictate what procedures the physician can and cannot perform, and under what circumstances.

Physicians who open lines of communication about medical futility and palliative care early on should have an easier time guiding patients toward appropriate and beneficial treatment options at the end of life.[10] The physician is able to say, "I committed to letting you know when our focus needed to change from treating the disease to treating symptoms because the disease is no longer treatable. We have reached that point, and I would like to discuss some options I think would be most effective for managing your symptoms." It is important for physicians to discuss this transitional period in the patient's care as reassuringly as they discuss disease-fighting treatment regimens. Physicians should make clear that patients will continue to have a wide range of options for supportive care and that their access to physician resources will not change. This will help patients remain confident about the plan of care and not feel abandoned when disease-fighting regimens are no longer an option.

Physicians should encourage patients to involve family members, where appropriate, in making decisions about end-of-life care. Physicians may want to review with the patient his or her prognosis, and the reasons that some care options are more beneficial than others at this point. Physicians should also share with patients that if a treatment regimen is not medically indicated, it is unlikely to be covered by insurance.

When Doctors and Patients Disagree: Legal and Ethical Considerations

Even the best communication efforts may not prevent disagreements between physicians and patients about which end-of-life care options are appropriate, and which are medically futile. As in this vignette, a patient may disagree with her doctor's assessment of medical futility, or want to receive a treatment despite its futility. Physicians are not obligated, either from a legal or ethical standpoint, to provide care that falls outside of the standard of care.[11] This includes medically futile treatments.

Where doctors and patients disagree about whether to pursue treatment that is medically futile, the AMA recommends a seven-step conflict resolution process.[11] The process requires physicians to attempt to establish an understanding with the patient about which treatments are futile, and which fall within acceptable limits. The process encourages joint decision making to the extent possible. When disagreements are not resolvable, the AMA recommends that physicians consult their institution's ethics committee. If the ethics committee supports the physician's position, the patient should be transferred to another physician or institution willing to provide treatment. If transfer is not possible, the intervention need not be offered.

The Texas Advance Directives Act (1999) provides an extrajudicial conflict-resolution process consistent with AMA recommendations.[12] If a physician does not want to provide "life-sustaining treatment" because he or she thinks the treatment is medically futile, the physician's assessment is reviewed by his or her institutional ethics committee. When the ethics committee's decision supports the physician, the

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physician must continue treatment for 10 days while the patient attempts to transfer. Patients (or their families) may take the physician and institution to court to extend the deadline for withdrawal of treatment. However, the statute offers immunity from civil and criminal prosecution for physicians and institutions that follow the process prescribed by the statute.[10,12]

It is unclear at this time whether chemotherapy may, in some cases, be considered a "life-sustaining treatment" under the Texas Advance Directives Act. The scope of this definition may be clarified over time as the Act is tested in the courts.

Physicians should be mindful that the processes recommended by the AMA and codified in the Texas Advance Directives Act are not consistent with many state laws. A majority of the states that permit physicians to decline to comply with patients' requests for medically futile treatments require physicians and institutions to continue treatment until the patient is transferred.[13] The same is true for physicians in Australia, Canada, and the United Kingdom, where physicians are not obligated to provide futile treatment, but may be required by law to provide life-sustaining care until the patient is transferred.[14-18] When a physician disagrees with a patient or surrogate over the provision of medically futile treatment, it is important for the physician to consult the laws in his or her home state, and the policies in place at his or her institution. In addition to the ethics committee, hospital lawyers and risk-management specialists may be good resources when disagreements arise.

Conclusion

Ongoing, open communication is likely to ease a patient's transition to appropriate and beneficial treatment options at the end of life. Physicians should act in concert with their ethical obligation to be a steward of this transition, and understand that—within legal and ethical boundaries—they are not obligated to pursue medically futile treatments.

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