

What has happened to clinical leadership in futile care discussions?

Brendan F Murphy

Treating clinicians need to make and own decisions about withholding futile treatment, instead of delegating them to patients' families who are usually ill equipped to do so

As a specialist physician for more than 20 years and, more recently, as a senior health manager, it has become apparent to me that staff at all levels across the hospital sector believe that they are actively treating a proportion of patients for whom such treatment is clearly futile. In providing this treatment, clinical leaders are on some level aware that they are doing a disservice to these patients, their families and the community, but seem ill equipped or unwilling to deal with the psychological, social and perceived legal challenges encountered in withholding futile treatment.

Futile treatment

The definition of futile treatment is complex and has been discussed in detail by others.¹ One simple definition is treatment that gives no, or an extremely small, chance of meaningful prolongation of survival and, at best, can only briefly delay the inevitable death of the patient.

It is helpful to use an example to illustrate: in my former clinical practice as a nephrologist, cases similar to that in the Box were becoming increasingly frequent.

There are, of course, a variety of other clinical circumstances where treatment might not be strictly futile (in terms of prolonging survival) but in which complex quality-of-life issues are an important part of the decision-making process. For example, antibiotic treatment of curable pneumonia in a patient with advanced dementia who might then live some years would not be regarded as futile therapy but might still legitimately be questioned. In such situations, early consultation with patients, advanced care directives, and legal next-of-kin consent for incompetent patients are required. While there may be good arguments to not pursue active treatment in some of these cases, the context is quite different from that of futile treatment and requires a different approach to that proposed here.

Futile treatment and the law

Clinicians are under no moral or legal obligation to provide futile treatment² and, indeed, I would contend that their obligation is to withhold treatment that keeps patients from their families and is invasive and unpleasant, in the absence of any likely survival benefit. Why, then, do clinicians pursue this course of action in the knowledge of its folly? Usually, when questioned, the response from clinicians in the common situation of an incompetent patient is: "Because the patient's family or next of kin want us to do everything". This is poor practice on two grounds: because futile

treatment should not be continued even if apparently desired by the next of kin; and because, in my experience, most next of kin will accept a decision to withhold futile treatment, as long as they are not being asked (as is commonly the case) to personally make what they see as a life-ending decision.

The legal situation is quite clear in all jurisdictions. Competent patients, or those holding authority to act on behalf of incompetent patients, cannot demand treatment that clinicians believe to be futile.² This includes such treatment as cardiopulmonary resuscitation (CPR), dialysis, ventilation and, in some circumstances, even enteral or intravenous nutrition. It is quite surprising how little awareness of this legal situation there is among medical staff. Junior doctors often believe that consent of the next of kin is required to withhold CPR, when, in fact, even if the next of kin desires the patient to have CPR, they have no legal right to demand it if the treating clinicians consider it futile.

Futile treatment and decision making

In part, the current problem with clinical leadership in futile treatment relates to a misperception of the role of inclusiveness in decision making. Twenty-five years ago, medical leaders in hospitals were seen as decisive, but not in an inclusive way. Decisions would be made

at the end of the bed, and the patient, his or her family, and the rest of the clinical team would, hopefully, be informed of the decision but not included in the decision-making process. Rightly, the educational and ethical framework has changed, such that it is now the norm to have multidisciplinary decision-making processes and to fully inform patients and their families about all aspects of care and clinical decisions. Unfortunately, some clinicians have interpreted this involvement of families in the clinical decision-making process for incompetent patients as a reason to delegate some of the clinical team's decisions to the family, who, at the time, are ill equipped to deal with them.

To illustrate this point, consider the case outlined in the Box. My approach to the family of this incompetent patient was to say that dialysis was not going to offer meaningful prolongation of survival and would be very unpleasant, and therefore that "the clinical team has decided not to offer this treatment and we will instead offer palliative care". The more recent approach, with the misguided view of inclusive decision making, would be to give the family the gloomy prognosis but then leave them with the terrible question: "Do you want us to provide dialysis (which might be life-sustaining for a short period of time) or do you want us to not

An 88-year-old man is admitted with advanced renal failure for consideration of maintenance dialysis treatment. He is bed-bound, with longstanding type 2 diabetes, dementia, widespread macrovascular and microvascular disease, amputations, poor vision and advanced ischaemic cardiomyopathy.

From clinical experience and registry data, nephrologists know that, while dialysis in the short term might provide some prolongation of life (perhaps weeks or months), it will be at the price of a long-term inpatient stay (probably until death), frequent vascular access surgery and a high risk of even earlier death from the complications of treatment. Maintenance dialysis treatment is therefore reasonably seen as futile in this clinical context. ♦

perform dialysis and instead provide palliative care?" In effect, the family hear this question as: "Do you want to make the decision to end the life of your loved one or do you want us to keep trying with a life-prolonging treatment?" While some spouses, children or other relatives may have sufficient psycho-emotional strength to deal appropriately with this scenario, many do not and will revert to the base position of "do everything, including dialysis", in the mistaken belief that seeing their relative suffer and die despite treatment is better than living with the terrible responsibility of their (incorrect) belief that they consented to the death. Compare this with my approach, where the family are left with the view that the clinical team could do no more and decided that palliative care was best. In my experience, most families took comfort from this approach.

A more common example is the decision to withhold CPR, which is usually made in the context of the treatment being considered futile for an incompetent patient. Modern practice would dictate, appropriately, that such a decision should not be made without full consultation with the family or next of kin. This is commonly misinterpreted by clinicians as a requirement for formal consent from the family to withhold CPR which, when asked for, is often refused for the same reason as given above. Few people are emotionally equipped to deal with a decision that they misinterpret to mean they let their relative die when his or her heart stopped. It is much better for them to know that the decision not to perform CPR was made and owned by the treating clinicians who have judged that they can do no more for the patient and that CPR would serve no purpose.

Futile treatment and leadership

Discussion with families about withholding futile treatment will always take considerable time, which must be allowed for, to ensure a full and complete picture is provided and their many inevitable questions can be answered. Families may request additional time to come to terms with a decision or even to gain another opinion on the prognosis and the futility of treatment. These requests should be granted, but with the understanding that it is the province of the clinicians to make these decisions. Very occasionally, some families will refuse to accept the clinical decision and will seek support from the legal system. Health services should support and welcome these rare legal challenges as an objective endorsement of actions to support the primary duty of care to the patient. There has not been a case where a court in Australia or the United Kingdom has overturned a carefully considered decision by a doctor to withhold treatment that is considered futile.³

While I have referred to clinicians and the clinical team, and strongly believe that treatment decisions are the province of the whole team, it is clear that the community looks to the (senior) medical practitioners for the security they need to accept decisions of great moment, such as withholding futile treatment. It is most important that the senior medical members of a hospital team be prepared to play a leadership role in these discussions and, based on their clinical experience, be prepared to make statements and communicate decisions in a way that inspires confidence in others. This leadership issue is therefore largely a problem of the medical profession. Indeed, junior medical staff and nursing and allied health staff in hospitals are often left with the consequences of poor or absent decision making by senior staff and will likely welcome the rebirth of leadership.

Withholding futile care is not about saving money for the health system. The primary reason for clinicians to withhold futile care is to enable them to do their best by their patient. Certainly, some resources might be freed up, but only to be used by the many other patients with treatable conditions who are waiting for hospital care and may, indeed, cost more to treat.

I strongly encourage medical leadership groups within and outside of health services to raise and debate this issue and call for a re-evaluation of the relevant parts of undergraduate and postgraduate medical education curricula. This is not an issue that requires legislative change or widespread community debate; it is merely implementing good practice in the best interests of patients and is within the existing power of medical clinicians to effect change today.

Competing interests

None identified.

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