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Futile Care for the Terminally Ill: It May Be Legal But Is It Ethical or Morally Justifiable?

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Medical futility is a very difficult, if not impossible term to define precisely. It all resides in the eye of the beholder. If a patient with terminal, incurable non-reversible Alzheimer's disease is close to the end, the physicians and other caregivers may feel it is futile to hydrate or nourish this patient and may recommend withholding or withdrawing the feeding tube and IV hydration. The medical literature has conflicting reports about whether or not starvation and/or dehydration makes a terminally ill dying patient more comfortable or less comfortable. If such a patient suffers a cardiopulmonary arrest, the physicians and other medical staff will probably feel that it is futile or fruitless to attempt cardiopulmonary resuscitation measures since they would serve no useful purpose. On the other hand the family may feel that such attempts are worthwhile and not fruitless. If blood circulation and respiration, albeit with mechanical assistance can be reestablished even for a few minutes or more, the patient's next of kin may feel that to be a worthwhile result. They can spend a little more time with their loved one before the final irreversible terminal event occurs.

There may also be disagreements among the medical staff and the family of a patient about whether or not certain "standard" medical interventions are futile in this particular patient. If a terminally ill Alzheimer's patient develops pneumonia, is it appropriate to treat it with antibiotics or is such therapy futile and without merit and should be withheld so that nature can take its course? If such a patient develops a hemorrhage, should transfusion therapy be given or is that futile since it serves no useful purpose and will not change the fatal outcome. The family may argue that antibiotics and/or transfusion therapy should be given to treat these intercurrent happenings as if they are not related to the underlying disease. Even some medical staff may agree with the latter viewpoint. However, suppose this Alzheimer patient now suffers from repeated respiratory infections, cannot bring up secretions by herself and is very uncomfortable and short of breath and dyspneic. Is that the time to withhold antibiotics since that episode of pneumonia is not an independent occurrence but part and parcel of the terminal phase of this patient's disease and life? Many medical staff and even ethicists would argue that antibiotics at this late stage of the disease are not indicated and in fact are futile and fruitless since they will

serve no useful purpose. Yet the family may insist that everything be done including the administration of antibiotics, respiratory support if necessary and certainly hydration and nutrition which every human being is entitled to until the very end since life is precious and every moment of life is precious.

It is obvious that all comfort measures must be given to every terminally ill patient who is suffering from physical pain, or mental or spiritual pain. The science of pain management (physical and mental) is now a well understand science and is mostly practiced appropriately, depending on the situation. A patient with terminal cancer in severe physical pain may need much more than a four hourly dose of narcotic analgesic. The patient may need a continuous infusion of a cocktail of several drugs. Ideally, the patient should control the flow of the infusion and self regulate the pain relief medication. Studies have shown that patients who control their own pain medication administration utilize less total narcotics than do patients who have to request pain relief as needed.

Certain situations are such that cardiopulmonary resuscitation measures are not futile and should be attempted with great vigor. For example, if a near drowning victim is extracted from a lake and is hypothermic with no pulse or spontaneous respiration and even has a flat encephalogram showing all the usual signs and symptoms of death, all attempts at cardiopulmonary resuscitation should be made because many such patients can be revived and may live normally for many years, often with no or very minimal neurologic sequelae. So too if a person is struck by lightning and has all the appearances of being dead [no pulse, no spontaneous breathing or movement, coma, flat electroencephalogram (EEG), absent calorics, etc.], all attempts at cardiopulmonary resuscitation should be made because there is a reasonable chance that they may be successful and return the patient to sentient life.

Other situations are clearly futile and cardio-pulmonary resuscitation (CPR) attempts are inappropriate, ineffective, fruitless and without useful purpose. For example, a young woman dying of widespread metastases from breast or ovarian cancer should be categorized as "Do Not Resuscitate (DNR)." Most often the physicians have already spoken to the patient and explained to her the

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futility of CPR even including adverse possible effects from the CPR (e.g. fractured ribs). If the patient or family refuses to sign a DNR order, two physicians can document in the chart why CPR would be futile and therefore not attempted. If the patient and or family insist that if CPR can even only temporarily reestablish cardiopulmonary function, it is not futile but worthwhile because every moment of life is worthwhile, even when very close to death, the medical staff should and will honor the request not to attempt CPR.

Many end of life decisions involve the issue of quality of life. If a person is in a persistent vegetative state or permanent coma with no hope of waking up from that coma, the family, as in the Nancy Cruzan case in Missouri, may argue that the quality of life of the patient is very poor. Not only does the family sign a DNR order but may also request that no heroic or extraordinary measures be applied to artificially prolong the patient's life. The family may argue that antibiotics for infections or transfusion for hemorrhage should not be given because they are futile and would not change the outcome of the persistent vegetative state. In the case of Nancy Cruzan, the parents successfully petitioned the Supreme Court of Missouri to allow the removal of the patient's feeding tube in order to let her die in dignity. Two weeks later, Nancy Cruzan was dead. Legal and ethical scholars applauded the court's decision. Lone dissenters argued that removing the feeding tube was an act of murder or manslaughter since that was the direct and proximate cause of her death.

When it comes to quality of life decisions, I believe only the patient can decide what quality of life is acceptable and tolerable, not the family or other surrogate includ-

ing the medical staff unless it is clearly in the patient's interest to act or not act in a certain way. If there is clear and convincing evidence of what the patient's wishes are either by an earlier oral or written declaration or living will, then the patient's wishes should certainly be followed.

The issues of medical futility and the implementation of CPR or DNR are complicated topics and must be evaluated and adjudicated on an individual basis depending on the specific circumstances of each case. No two cases are identical and it is therefore difficult to develop broad guidelines for a decision about death and dying and medical futility. Each case must be individualized and all the medical and surrounding circumstances taken into account. The patient's wishes should always be honored and followed, unless there are cogent and compelling reasons to do otherwise. Pain and suffering must be relieved to the very end. This includes both physical pain and mental suffering. The clergy and social work services are underutilized helpful resources in most settings where a patient is dying. The same applies to family and friends comforting the dying in any possible manner. It is an absolute obligation upon every human being on behalf of another dying human being since we were all created in the image of God. Whether terminal hydration and nutrition is part of that obligation is a matter of dispute among the legal, medical and spiritual experts and among the lay public where opinions are divided.

NOTE

The author is indebted to Jacqueline Engracia for typing this manuscript.