Surgical Ethics Challenges

Futility and surgical intervention

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An 86-year-old man presents with a history of multiple endarterectomies, coronary grafting, and an infrarenal abdominal aneurysmectomy. He is now diagnosed with an 8-cm symptomatic thoracoabdominal aneurysm and emphysema with an FEV1 of 0.5 L. Patient and family insist on urgent surgical intervention. What is the best response?

A. Refer the request to the hospital’s ethics committee.
B. Refuse the request as inappropriate.
C. Refer them to another surgeon because you are uncomfortable operating in this case.
D. Explain why surgery is likely to be futile in this case, and recommend palliative care.
E. Involve Risk Management in subsequent discussions with the patient and his family.

The best response is D. Limits on the obligation to preserve life have been understood in medicine throughout history. The dramatic success of high-technology surgery and critical care since World War II has sometimes made medicine’s ability to extend life seem boundless, but of course it is not. Cardiopulmonary resuscitation and advanced surgical procedures have often been implemented with insufficient attention to associated morbidity and lost functional status, as many patients, families, and some physicians have refused to acknowledge limits to medicine’s obligation to preserve life.

Despite recent skepticism,1 clinical assessments of futility can be made and reliably implemented. "Futility" means that the therapeutic goal of a clinical intervention is unlikely to be achieved. The key clinical issues in assessing futility therefore become the specified goal and the evidence that it is unlikely to be reached. Four senses of futility are relevant to the specification of goals2:

1. “Physiologic futility” is recognized when the intervention is reliably expected not to produce its desired physiologic effect. Cardiopulmonary resuscitation is routinely discontinued when it can no longer be expected to restore spontaneous circulation and respiration.

2. “Overall futility” reflects a reliable expectation that the intervention will not restore the patient’s capacity to interact with the environment and continue human development. Antibiotics for management of opportunistic infections can justifiably be withheld from patients in a persistent vegetative state.

3. “Imminent demise futility” characterizes a reliable expectation that the patient will die before discharge and not recover interactive capacity before death.

4. “Quality of life futility” applies when the patient’s current or projected condition will result in an intolerable inability to engage in or derive pleasure from life.

In this case, there are two likely outcomes of surgical intervention; first, that the patient will die during or shortly after surgery, and, second, the patient will survive but not be weanable from ventilation, thereby losing any remaining interactive capacity. Blackhall3 set the standard for physiologic futility at a 98% to 100% expectation of failure to achieve the desired outcome. This case may not meet that standard, but it can be seen as exemplifying either imminent demise futility or overall futility.

The surgeon should meet with the patient and his family to discuss the prognosis of overall or imminent demise futility. The surgeon should explain that surgery would not be in the patient’s best interest and that a comfortable and dignified death is the most appropriate available goal. The surgeon should make a referral to hospice care. If the patient continues to insist on surgery, the surgeon should consider referral to the hospital ethics committee (choice A).

The problem with refusing to perform inappropriate surgery (choice B) resides in the term’s vagueness when clinically applied. The four concepts of futility can help to clarify the surgeon’s reluctance to operate when the outcome will be poor. “Uncomfortable” is an even fuzzier term in clinical discourse and so, until an attempt has been made to reason with this patient and his family, option C is premature. Finally, surgeons should not rely upon risk managers for clinical guidance in potentially conflictual situations (choice E). Rather, surgeons should form clinical ethical judgments carefully as patient fiduciaries and guide themselves and their patients accordingly.

REFERENCES