



## PALLIATIVE CARE CASE OF THE MONTH

### “80 year old patient with advanced gastric cancer When are medical interventions considered “futile?”

by

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**Case:** Ms. K is an 80-year-old female with a history of gastric cancer diagnosed several years ago. Although at first resectable, the patient and family initially refused conventional treatments. Over the next six months she was admitted ten times for aspiration pneumonia and other infections. She also had recurrent anemia from gastrointestinal blood loss requiring recurrent blood transfusions; these left her with alloantibodies making locating compatible blood products difficult. With each admission, the patient was weaker and became bedbound with progressively worse delirium. Despite this decline, the patient’s family was convinced that there would be a miracle. They now wanted to pursue conventional therapy and hoped the patient would be able to receive chemotherapy. The medical staff was quite distressed; they felt that the patient was suffering, and the medical interventions were futile in the context of her advanced gastric cancer

**Clinical Question:** As technology advances, we have more opportunities to extend patients’ lives, particularly in large academic centers with seemingly unlimited resources. This poses challenges to providers and raises the question of futility. What is medical futility? At what point is the medical team no longer obligated to provide a particular intervention?

**Discussion:** A review of the literature yields many different definitions of and opinions about medical futility. Qualitative futility defines futility as an “unacceptable likelihood of achieving an effect that the patient has the capacity to appreciate as a benefit”. This definition requires the clinician to understand what the patient would find an acceptable quality of life.<sup>1</sup> For example; a patient may feel that prolonged survival on a ventilator is unacceptable. A treatment which could only result in prolonged ventilator dependence would therefore be futile for this patient. Quantitative futility, on the other hand, defines futility based on a specific intervention that has a one percent or less chance of leading to survival. A third way of viewing futility, physiologic futility, is when an intervention is unlikely to have any physiologic effect on the body (i.e. a treatment cannot be considered futile as long as it maintains a body function).

Most recent ethics discussions of futility do not use these concepts of qualitative, quantitative, and physiologic futility. Instead ethicists argue that “futile” is impossible to define and that the term tries to medicalize a value disagreement. They recommend, instead, referring to treatments that the clinicians believe are inappropriate.

This problem has led health care providers to try to develop processes to resolve these conflicts between patient, families and clinicians. At UPMC,<sup>2</sup> we have a policy concerning the resolution of intractable disputes related to life-sustaining measures. It is designed to be used as a “last resort” after discussions and attempts at conflict resolution are made. Palliative care and/or ethics consultation can be helpful in this process. Typically these conflicts are due to communication misfires rather than deep seeded value conflicts.<sup>3,4</sup>

If agreement cannot be reached through discussions, the procedure involves first obtaining a second opinion from within the hospital or at another institution. If an uninvolved physician agrees with patient/surrogate’s request and is willing to assume care, a transfer is made. If the dispute remains intractable, an ethics consult is sought. If all of these efforts fail to resolve the disagreement, the chair of the ethics committee initiates the Dispute Resolution Process. This creates a committee to resolve the conflict which hears both the attending physician’s and the patient/surrogate’s perspectives, deliberates in an attempt to find a negotiated solution and presents to a closed session of the ethics committee with recommendations generated by consensus. The deliberations are then conveyed to the patient/surrogate. If the ethics committee recommends withholding or discontinuation of treatment, the patient/surrogate is offered the option to seek transfer to another institution and is informed of their right to seek a court order. If the patient/surrogate is unable to find an accepting institution or if no court order to continue treatments is obtained, the medical intervention under consideration will be discontinued or not initiated.

*Personal details in the case published have been altered to protect patient privacy.*

For palliative care consultations please contact the Palliative Care Program at PUH/MUH, 647-7243, beeper 8511, Shadyside Dept. of Medical Ethics and Palliative Care, beeper 412-647-7243 pager # 8513, Perioperative/ Trauma Pain 647-7243, beeper 7246, UPCI Cancer Pain Service, beeper 644 –1724, Interventional Pain 784-4000, Magee Women’s Hospital, beeper 412-647-7243 pager #: 8510, VA Palliative Care Program, 688-6178, beeper 296. Hillman Outpatient: 412-692-4724. For ethics consultations at UPMC Presbyterian-Montefiore and Children’s page 958-3844. With comments about “Case of the Month” call Dr. Robert Arnold at (412) 692-4834.



**Resolution of Case:** In Ms. K's case, the family relayed that Ms. K would want to be kept alive long enough so that she would, with God's help, be able to receive cancer-directed therapies. Treatments for Ms. K, including repeated admissions and treatment with antibiotics for aspiration pneumonias as well as blood products for anemia, were keeping her body alive to that end. In a qualitative sense, the treatments she was receiving were not futile, though the family's hopes were based on something that lay outside of medical science. However, in a family meeting, the palliative care team discussed with the patient's family that if Ms. K were to undergo a cardiac arrest in the setting of severe anemia and compatible blood products were unable to be found, performing CPR would be physiologically futile as the clinicians would be unable to treat the underlying cause of the arrest. CPR would likely hasten her death. The palliative care team met with the patient's family, explored their emotions and reasoning, and supported the goal of keeping Mrs. K alive as long as possible while hoping for a miracle. At the same time, they let Mrs. K's family know that the medical team could not offer CPR in the event of cardiac arrest related to her intractable anemia, as this would not help meet her goals. During Mrs. K's final admission, she became hypotensive and unresponsive. It was clear to the medical team that she was dying. There was no blood available, and there was no timeline as to when it would be obtained. In this setting, transfer to the ICU with intubation and initiation of pressors would not have altered Mrs. K's course. The palliative care team focused on supporting the patient's proxy through the inevitability of the patient's death and not offering treatments which were physiologically futile. After lengthy and often emotionally-charged discussions with the patient's medical POA, the decision was made to keep her comfortable on the floor as long as blood was unavailable. The patient died several hours later.

In this case, the team was able to avoid using a legal process involving our hospital's futility protocol. Instead, through intensive communication and conflict resolution with the family and including medical ethics, palliative care and the patient's PCP (as well as the primary team), we were able to both respect the family's values and the distress of the clinicians caring for her.

#### References:

1. J Bioeth Inq. 2011 Jun;8(2):123-131. Defining Medical Futility and Improving Medical Care.
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3. Mayo Clin Proc. 2014 Jul;89(7):943-59. Ten common questions (and their answers) on medical futility.
4. Ann Internal Med. 2009; 151:345-349 Discussing Treatment Preferences With Patients Who Want "Everything"

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