Medical Futility

WHEN IS ENOUGH ENOUGH? WHO DECIDES?

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Knowing when to stop...

- Is a recent dilemma
- Curative medical interventions not available before modern medicine
- Now, an endless array
- Difficult and painful wrestling process
FUTILITY – when? what?

- **Past:** Do anything and everything possible
- **Today:** because can do, does not equate MUST do
- **Definition:** useless or ineffective
FUTILITY = ineffective

• Clinical futility:

Obvious - don’t keep decapitated on life support

Difficult - PVS patient? Alzheimer's? When stop life support?
FUTILITY = useless

- Does not provide a benefit
- BENEFICENCE (patient well-being)
- Proportionality: benefit vs. burden
Ethical and Religious Directives

“A person has a moral obligation to use ordinary or proportionate means of preserving his or her [physical] life. Proportionate means are those that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or community.” (#56)
“A person may forgo extraordinary or disproportionate means of preserving [physical] life. Disproportionate means are those that in the patient’s judgment do not offer a reasonable hope of benefit or entail an excessive expense on the family or community.” (#57)
ORDINARY/EXTRAORDINARY

- **Clinical:** ordinary = common, easily done, inexpensive, effective physical outcome

- **Ethical:** relates to benefit vs. burden ratio regarding deeper levels of functioning, i.e., psychosocial/spiritual dimensions
FUTILITY
Ethical Dimensions

“Quality of physical functioning”
(relates to bodily functions)

Vs.

“Quality of Life”
(relates to integrated functioning)
“We have a duty to preserve our [physical] life and to use it for the glory of God, but the duty to preserve [physical] life is not absolute, for we may reject life[body]-prolonging procedures that are insufficiently beneficial or excessively burdensome.”

(Part Five: Issues in Care for the Dying, introduction)
FUTILITY

• Not just a question of good clinical outcome

• Must also address: Is physical functioning still capable of supporting cognitive/affective functioning?
WHO DECIDES BENEFIT/BURDEN

- Obviously: PATIENT

- AUTONOMY

- Incapacitated/incompetent patient: who decides?
1) Living Will Declaration (1979)


3) Out of Hospital DNR (1994)
Previously, guardian did not have power to make decisions on the withholding or withdrawal of life support.
Guardian can now consent to these:

(A) Following the ward’s directive in LW Declaration;

(B) Following ward’s directives given in DPOAHC;

(C) When two physicians concur that further treatment is futile. Certification is approved by a judge.
Kansas Uniform Health-Care Decisions Act (proposed)

- Rescinds previous Advance Directive legislation
- Incorporates a new Advance HealthCare directive (section 4)
- Provides a Surrogacy provision (section 5)
Decisions by Surrogate

“...in descending order of priority, [the following] may act as surrogate:

(1) The spouse, unless legally separated;
(2) An adult child
(3) A parent; or
(4) An adult brother or sister”
If none of the above are available, then:

“...an adult who has exhibited special care and concern for the person, who is familiar with the person’s personal values, and who is reasonably available may act as surrogate.”
Multiple members of one class without agreement?

“...the supervising health care provider shall comply with the decision of a majority of the members of that class...”
QUESTIONS/COMMENTS