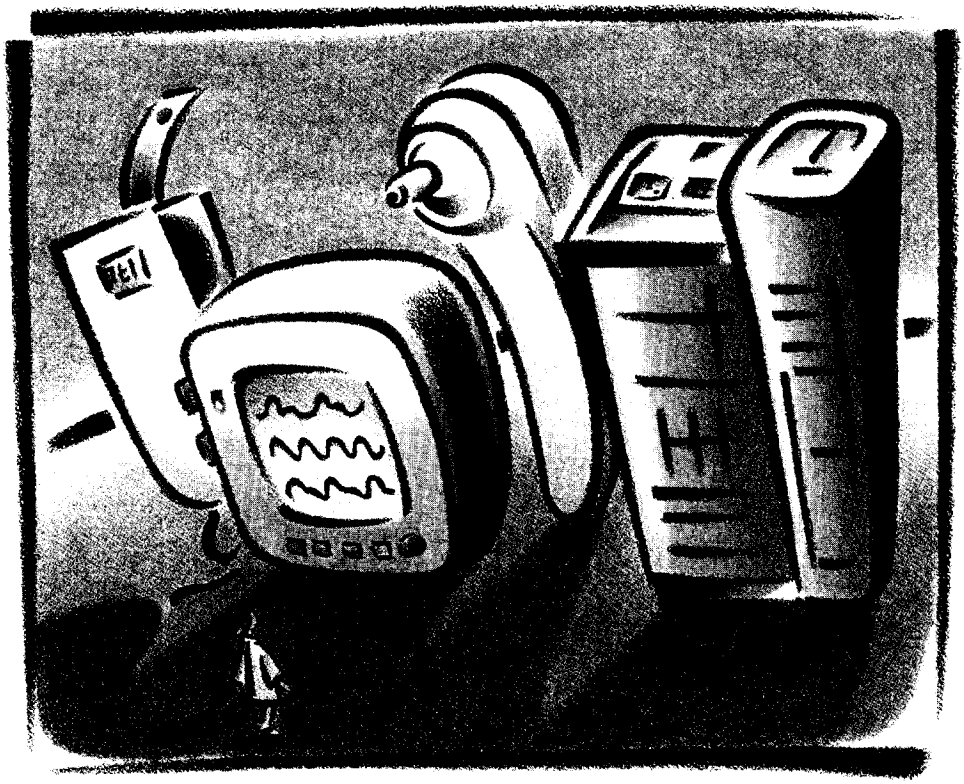
Medical devices and medical futility: When is enough enough?



LEARN PRACTICAL WAYS TO GRAPPLE WITH A COMPLEX ETHICAL ISSUE.

As never before, nursing and technology walk hand in hand. Today, devices such as portable infusion pumps, vital signs monitors, and pulse oximeters are woven into the fabric of nursing care.

At the same time, these high-tech tools raise nettlesome ethical dilemmas. For example, does a full code really benefit a patient if the intervention leaves him to languish in a persistent vegetative state? At what point does the use of medical technology compromise patient dignity? In short, when is enough enough?

The answer to that question is neither obvious nor simple. Often, it depends on whom you ask—the patient, the family, the physician, or other health care providers. And almost always, no one answer is entirely right.

In this article, I'll help you understand some of the issues involved with the use of medical technology and offer ways to approach the question *When is*

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enough enough? First, though, let's look at why technology has become so important in health care.

TECHNOLOGIC IMPERATIVE

Although sophisticated medical devices don't guarantee quality patient care, they're everywhere—in hospitals, home health care, and other settings. Their mere existence often mandates their use.

One reason sophisticated devices are so prevalent is simply that we're passionate about technology. Most of us equate medical devices with improvement in the human condition, regardless of how effective they really are.

A second reason is that patients and families often equate devices with quality care. They may view the use of fewer medical devices as giving up on the patient.

Finally, fear of litigation spurs clinicians to use technology for diagnostic tests and interventions. They fear that not doing "all that we can" may be seen by families, the courts, and the media as negligence—regardless of the probable patient outcome.

DEFINING MEDICAL FUTILITY

When a medical device is used, especially for a critically ill patient, the issue of medical futility may not be far behind. As with most ethical issues, no single definition captures the essence of medical futility. In the past, medical futility referred to unwanted care. Today, unwanted care is less prominent, thanks primarily to the Patient Self-Determination Act.

Now clinicians may focus on quantitative futility (also called physiologic futility), which relies on statistical analysis. Because an intervention has failed many times in the past, this approach says that using it in the present case will also be futile.

Other clinicians focus on qualitative futility. Using this definition, futility exists when an intervention only sustains unconsciousness or doesn't end a patient's total dependence on intensive medical care.

In general, treatments can be classified as:

- *not futile*—beneficial to the patient's well-being from both the patient's and clinician's perspective
- *futile*—not beneficial to the patient's well-being from both the patient's and clinician's perspective
- *futile from the patient's perspective*—the patient neither values nor desires the medically indicated treatment
- *futile from the clinician's perspective*—the patient values and desires treatment not medically indicated.

Of these, the third situation would be problematic only if the clinician disregards patient autonomy. But only the last situation is truly problematic because it pits professional autonomy against patient autonomy. Some experts believe that patients have no claim to futile, nonbeneficial, or inappropriate medical care. Others believe that clinicians should generally accede to a patient's wishes.

WAYS TO RESPOND

However futility is defined, the controversies surrounding the use of medical technology are likely to grow in coming years—especially as managed care continues to stress cost-effective care. Although definitive answers about medical futility are difficult, if not impossible, to provide, these suggestions can help you grapple with the issue.

General considerations

- Remember that medical futility

WHAT'S BEHIND "QUALITY OF LIFE"?

Besides medical futility, medical device use raises questions involving quality of life. As with medical futility, an agreed-upon definition is hard to find. Here are some ways experts have tried to measure quality of life:

- Normal life—the ability to function at a level similar to others who are healthy or the same age; patient is asymptomatic
- Happiness/satisfaction—happiness refers to short-term positive feelings; satisfaction, to an assessment of life's conditions (and may pertain more closely to quality of life).
- Personal goal attainment—success or failure in attaining one's individual goals
- Social utility—the ability to lead a socially useful life
- Natural capacity—an individual's actual or potential physical and mental capabilities.

As these definitions show, quality of life is multidimensional and focuses on more than just health concerns. Individuals value different things. Evaluating quality of life helps us assess the effect of medical and nursing interventions on patients and their lives in terms of values that matter to them most.

can be determined only in the context of each patient's situation. For example, administering antibiotics to an otherwise healthy patient who has pneumonia isn't futile. But administering antibiotics to a patient who's in a persistent vegetative state could be considered futile.

- Clarify your own values about "when enough is enough." Knowing what you believe and understanding the basis for your beliefs may make it easier to maintain a therapeutic relationship with patients and their families. Plus, if you're comfortable with your own beliefs, you may be better able to respect and accept other opinions.

Patient advocacy

- Develop your patient advocacy skills. Patient advocacy typically means standing in the middle of a conflict between patients and other health care professionals and unearthing the values and beliefs that underlie the patient's or surrogate's demands for treatment. Those beliefs could include unrealistic expectations of the treatment, assumptions that professionals won't act in the patient's best interest, and the conviction that life is to be preserved at all costs.

Patient advocacy also means uncovering the factors that make professionals uncomfortable about those demands for treatment. These include escalating health care costs, concerns that resources used for one patient (donated organs, for example) won't be available for another, and beliefs that aggressive treatment may not be in the patient's or family's best interest or that treatment may be cruel and inhumane.

- Get to know the patient, his surrogate (if he has one), and his family. Find out what their goals are when they request medically futile treatment. Discussing those goals helps uncover and address the moral appeals at the core of conflicts among patients, families, and health care providers.
- Base decisions on a patient's best interests rather than those of the surrogate or health care professional. To do this, you'll need to differentiate the patient's feelings from others' feelings.
- At the first indication of a potential conflict over patient care, convene a patient-care conference that includes the patient, family, and health care professionals. Such conferences typically unearth confusion about treatment goals. Families who are consistently informed about changes in a patient's condition and helped to understand those changes are less likely to mistrust the care team if they recommend withdrawing or withholding further aggressive treatment.
- Try to prevent conflict by:

1. focusing all conversations on achieving the best outcome for the patient
2. identifying the health care professional whom the family and patient trusts most and having this person present at all conversations about treatment options
3. having health care professionals make ongoing, consistent recommendations to the family
4. communicating person-to-person.

If conflicts occur, resolve them through negotiation. One expert recommends that nursing lead the health care team in negotiation. The focus in negotiation or mediated compromise is on everyone working together toward the best possible outcome for the patient.

Hospital involvement

- Find out if your hospital has an ethics committee. Could this committee help in cases involving medical futility?
- Find out if your hospital has a medical futility policy. Some hospitals have developed these in anticipation of families asking physicians for treatments deemed medically futile. These policies explain in advance the kind of treatments the hospital won't provide or the procedures it will follow in the event of such conflicts.

Final tips

- Be proactive. Make sure you explain advance directives to patients. Encourage them to make their medical care preferences known and to appoint a surrogate.
- Help your patient and family understand that hospice is about care, not cure—retaining dignity and control, not giving up. Also let them know that they can stop hospice care and resume more aggressive medical care if they wish.

ANSWERING THE QUESTION

As patients, families, health care professionals, and society come to terms with the issues that technology raises, nurses' ability to maintain a therapeutic relationship with patients and their families becomes crucial. This expertise is based on nurses understanding themselves and their values, knowing patients as unique individuals, respecting differences of opinion and judgments, and being willing to work toward common goals. With this approach in place, nursing and other health care providers can then hope to answer the question, *When is enough enough?*

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