

Getting to “No” You: Ethical Issues in End of Life Care

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“Is It Wrong to Provide Futile CPR?”

Truog, NEJM Feb 11, 2010

- 2 yo, frontal encephalocoele.
- No meaningful neurologic function.
- Parents refused palliative care, DNR.
- Multiple ICU admissions.
- Cardiac arrest, CPR, multiple attempts at central & intra-osseous lines.
- “Futile and brutal”
- Parents said “thank you.”



Truog: Justifications

- Not all families share the vision of a good death as peaceful and comfortable
- “Giving up” unacceptable in this family’s culture
- Family might feel regret later.
- Treated the family with respect, care and compassion
- Patient’s interests had waned, no suffering; family’s psychological interests took priority



Concerns/Criticisms

- Where does this duty end?
 - Brain dead patient?
 - Recurrent CPR?
 - Accept for multiple admissions?
 - Dialysis, transplantation, home ventilator?
 - Other symbolic tests, treatments?
 - Serial MRI's, PET scans



Associated Press

Hospital Seeks to Pull Plug on Brain-Dead Boy, 12

Thursday, November 06, 2008

The hospital is seeking a court order that affirms its plan to disconnect the boy from a ventilator and to discontinue intravenous medications that keep his heart beating.



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Concerns/Questions

- Emotional toll on nurses, other physicians
- Using child's body and intensive care as a means of psychotherapy
- Dishonest to parents: pretending that resuscitation might succeed



Two more familiar issues

- Futile treatment won't go away
 - False legal fears (Risk may be zero)
 - Real political fears (Schiavo)
 - Perceived duty to family > patient
- *Discussing* rationing is still taboo
 - Clinton → Obama
 - Press
 - Key opinion leaders need to lift the taboo



Futility debate

- Consensus

- Medical futility: Rx will not achieve the medical goal for which it is designed.
 - E.g., Ventilator in pulmonary agenesis
 - Acknowledged to be rare
- Social futility: Rx works, but the quality of life does not justify the costs
 - Not a medical judgment
 - Must be negotiated with family, staff, to a point



Extreme social futility

- Patients with no plausible prospects for leaving the hospital alive or experiencing human interaction.
- Insistent families
 - Misunderstanding about prognosis
 - Religious views re sanctity of life
- Institutional fear of political consequences of overriding family wishes
 - Dominance of risk management considerations over patient's interests
 - Fear of going to jail > fear of going to hell



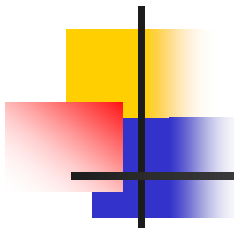
Legal vs political risks

- Difficult to find a single case of liability for withholding/withdrawing LSMT over family objection
 - MGH, CNMC prevailed
- Even active euthanasia is difficult to prosecute
 - Kevorkian: 100+ cases, 4 trials



Relevance of cost

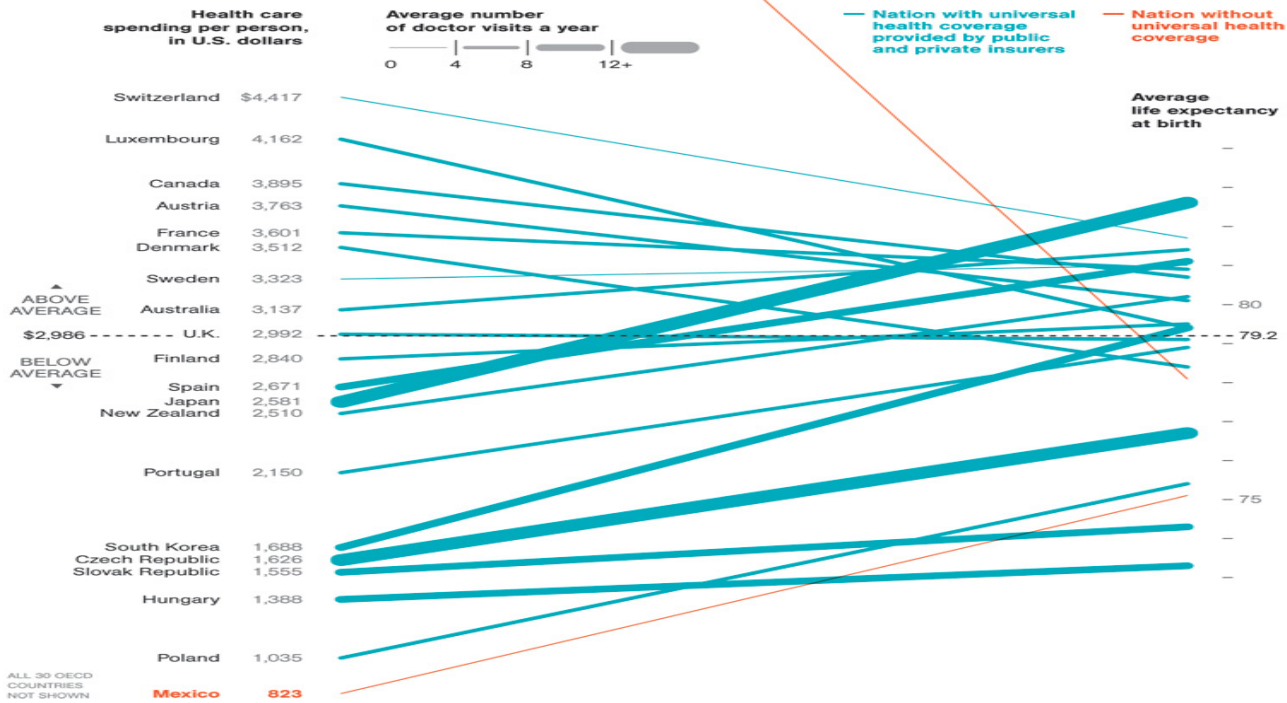
- Futility discussions become most contentious when linked with high-technology support
 - Burden on staff (“Abuse”)
 - Pressure on ICU beds
 - Questions about cost/QALY



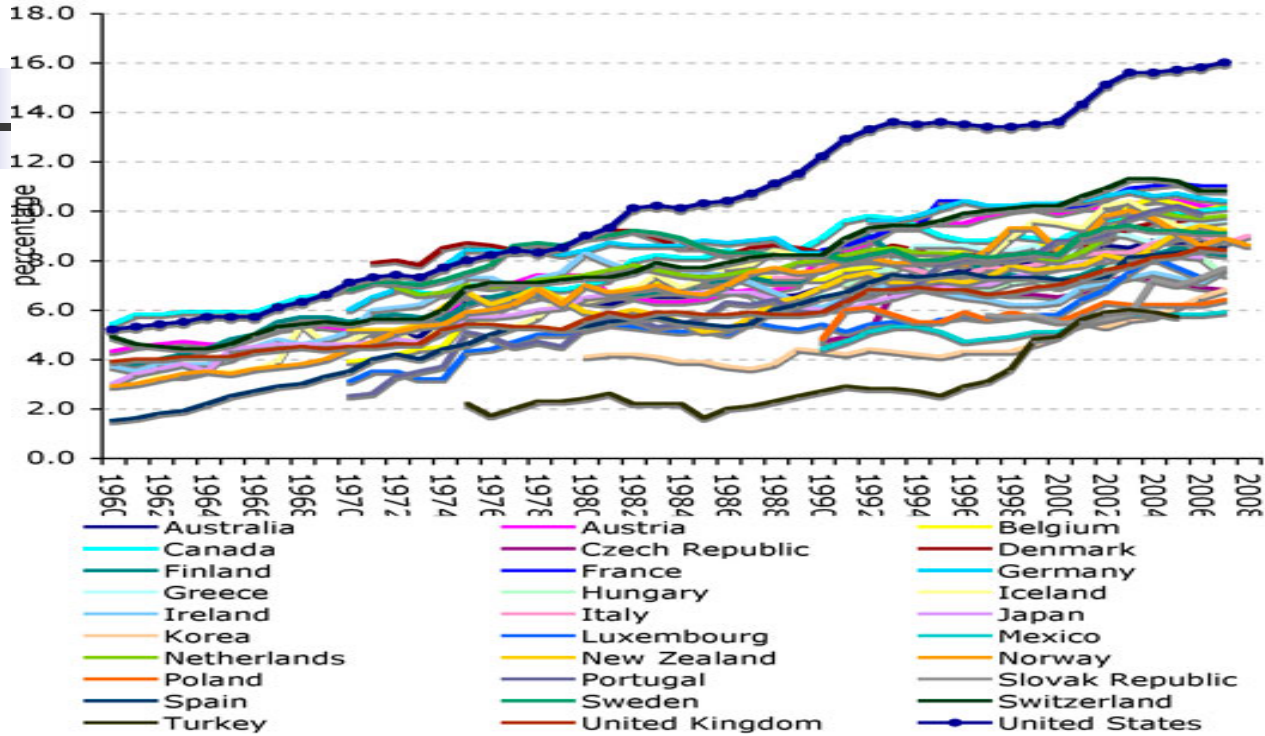
United States \$7,290

Dollar figures reflect all public and private spending on care, from doctor visits to hospital infrastructure. Data are from 2007 or the most recent year available.

GRAPHIC: OLIVER UBERTI, NG STAFF. SOURCE: "OECD HEALTH DATA 2009," ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT



National Health Spending as a % of G.D.P.





Perspective

- End of life costs not biggest contributor to runaway inflation, but not trivial
 - 27% Medicare \$300B budget for last year of life
 - Dirksen: "A billion here, a billion there...."
- Enormous variance
 - UCLA \$50K vs Mayo \$25K last 6 months
 - "If you come into this hospital we are not going to let you die." Dr Peter Feinberg, CEO
 - Could save \$700B if all were like Mayo
 - "We have no idea what we're getting for the extra \$25,000" Peter Orszag



Causes of inflation

- Administrative waste
 - \$300-400B savings if single payer
- Medical waste
 - \$300-\$500B ineffective dx/rx
 - E.g., Mammography age 70-79
- Aging population
- New expensive technology
- Eliminating waste is a one-time saving, only postponing the need to ration



Eliminating waste is a one-time saving

Cable TV, 10 channels, \$1/each

Double each year

	1	2	3	4	5	6
\$1	\$10	\$20	\$40	\$80	\$160	\$320
\$.50	\$5	\$10	\$20	\$40	\$80	\$160



Rationing as taboo

- Clinton Health Care Task Force
 - Directive not to use the word
 - Consumer panel
- Obama health care reform
 - Denied rationing would be necessary
 - Mammography: Assured it would always be funded at all ages



Mammography 70-79 yo

- If woman is at *high risk* for breast cancer, life expectancy will be increased by an average of 8 hours
 - Cost per QALY: \$1.2 million
- If woman is at *normal risk* for breast cancer, life expectancy will be **decreased** by 5 hours
- 40-49 yo: Increase in average life expectancy measured in days



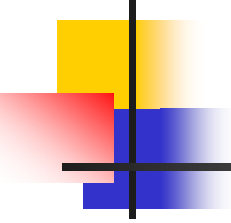
Futile CPR

- If we owe intensive care to all patients who want it, even when futile, we will never get to the discussion about denying effective care
- Rationing means denying effective care
- Leadership is needed to bring it out of the closet, into the mainstream discussions
 - Not whether to ration, but how



Conclusions

- Health care is a/the major cause of personal, business and governmental bankruptcy in the US and getting worse.
- There is no entitlement to all effective care, and certainly not futile care.
- People/institutions in leadership positions need to attack the taboo on discussions of explicit rationing.
- Need to get to “No” the people better.



“You can always trust the American people to do the right thing, after they have exhausted all of the other possibilities.”

Winston Churchill



Separator slide

- Following slides for possible use during discussion



Medical futility

- Can never say prospect for meaningful survival is zero
 - Misdiagnosis
 - Self-fulfilling prophecies
 - 1000 gm infant in 1964: “Not viable”
 - Anencephalic infants surviving 2, 14 years
 - 1/million is not zero
 - If \$1,000 per pt → \$1 Billion per life saved
 - Whether worth it is a value judgment



UCLA vs Mayo

- “If you come into this hospital, we’re not going to let you die.”

Dr. David T. Feinberg
CEO, UCLA Medical Center