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Reply to: “Judgment of Futile Care in the ICU”

Thanh Huynh Neville, MD, MSHS and

David Geffen School of Medicine, UCLA Department of Medicine, Division of Pulmonary and Critical Care Medicine, 37-131 Center for the Health Sciences, Box 951690, Los Angeles, CA 90095

Neil S. Wenger, MD, MPH

David Geffen School of Medicine, UCLA Department of Medicine, Division of General Internal Medicine and Health Services Research

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futile care; intensive care unit; futile treatment; shared decision-making

We thank Drs. Reddy, O’Horo, Hoskote, and Moua (1) for eloquently expressing their perspective regarding our publication on the opportunity costs of futile treatment in the ICU. Their primary concern is that the judgment of futility was made solely by the clinician and did not include the opinions of the patients and their families. We agree that the ideal paradigm of medicine is one of shared decision-making, where medical recommendations are discussed within the context of patients’ values and preferences. Far from advocating that patients’ and families’ opinions should be excluded, we believe that early frank discussion of prognosis and treatment options will lead to an improved match of treatments with patient values. However, this research recognizes what doctors in the foundational focus group told us: that there are some health states that critical care should not be used to perpetuate. Should critical care physicians not take responsibility for deciding when life-sustaining treatment is appropriate? A major part of a clinician’s training is learning which treatments are indicated—they decide when a patient should be hospitalized, what imaging studies are needed, when antibiotics should be started and stopped, whether a patient would benefit from surgery. Just as a family physician knows not to prescribe antibiotics for the common cold, the intensivist should avoid initiating dialysis on an imminently dying patient regardless of a family’s insistence. Clinicians have the responsibility to apply healthcare resources where they are indicated and to avoid the treatments that are unnecessary, non-beneficial, or harmful to the patient. The importance of critical care physicians carefully choosing which advanced, highly technical life-saving treatments are appropriate for which patients is perhaps best emphasized by considering the contrary circumstance: Families, imbued with no knowledge of medicine and encumbered by grief, choose whether patients receive mechanical ventilation, continuous veno-venous hemofiltration, and ventricular assist devices. Such a plan would not only be bad for patients, but would be an absurdly unfair use of health care resources. These decisions are inextricably linked with the

physician's responsibility for stewardship, and inappropriate critical care should not be provided simply because a patient or family "wants everything" (2). Thus, we argue that a clinician's assessment and recognition of futility *is* critically important and *necessary* in order to re-direct some families and relieve suffering.

Drs. Reddy *et al* also point out that the term "futile" is problematic because "many activities done in the context of critical illness serve quite well initial physiologic goals" without affecting survival. We agree that perhaps the term "inappropriate treatment" should replace "futile treatment" to avoid confusion with the concept of physiologic futility (3). The suggestion that the term "futile" should be avoided because Medicine is probabilistic at best is well taken. However, just as every patient has the right to hear the risks and benefits of any procedure, the critically ill patient and their family should be engaged in conversations regarding the likelihood that aggressive critical care would lead to a meaningful recovery. It is only then that a fully informed decision can be made.

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