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Case 4: Futility

Jim/Jane Wall – patient's son/daughter and surrogate decision maker
[played by standardized patient]
Dr. Murphy [played by Neiswanger faculty]
Ethics consultants [played by students]

Background

Mrs. Czarniszwicz was a 67-year-old woman who was diagnosed as having non-resectable colon cancer six months ago. When that diagnosis was made, it was clear that the patient would eventually die but it was, understandably, not clear exactly when. This is the most recent of several admissions from a nearby nursing home for episodes of sepsis (infection) believed to be secondary to the entrance of bacteria through the friable colon cancer. On admission, the patient's general health appeared to be poor. Mrs. Czarniszwicz looked emaciated with generalized edema (swelling) and skin excoriation (abrasions). She could not move her legs and had only gross motor movement of her upper extremities secondary to severe spinal disease. Mrs. Czarniszwicz communicated mainly by head movements such as nodding.

The patient was given antibiotics and steroids for treatment of the sepsis and made a "full code" based upon discussions with her. She said that she wished to be resuscitated should the need arise. Three days after admission the patient developed acute shortness of breath and a chest X-ray led to a differential diagnosis of congestive heart failure vs. pulmonary embolism. Mrs. Czarniszwicz also developed acute GI bleeding believed to be secondary to the colon cancer. Over the next few days, diagnostic tests gave no additional insight into the patient's condition and Mrs. Czarniszwicz continued to become lethargic and confused. (This could be accounted for in several ways including possible brain metastases from the cancer.) Her oxygenation was poor. Thus, she was intubated and admitted to the ICU.

The patient also developed a pleural effusion and further malignancy was suspected. She became septic and pneumonia was thought to be the likely culprit. The daughter, Jane, was asked what the medical team should do and he, like his mother upon admission, requested that "everything be done."

Over the next few days aggressive vasopressor therapy was begun to try and offset her dropping blood pressure. Nevertheless, pressure continued to drop and ranged between 30-40 systolic on maximum vasopressor therapy. Over the next 24 hours, the patient became anuric and developed massive generalized edema. She was oozing serous fluid from her skin and other puncture sites. Dr. Gamble called the ethics consultation service.

Ethics Consultants [played by students]

- This hospital has no explicit futility policy. There is a statement in a forgoing life-sustaining treatment policy that says physicians are not obligated to provide futile treatment. But the hospital's preferred approach is clearly consensus decision making with the family.
- You probably want to get the word 'death' on the table in this conversation and probably sooner rather than later. It is important to get the physician to either say he believes the patient will die soon and certainly will not survive this admission.
- Once the fact that the patient is dying is established, you'd like to shift the conversation to consider changing the goal of care from "prolonging the dying process" to "making the patient comfortable."
- If worse comes to worse, you'll have to decide if you need to limit your goal to simply getting the surrogate to agree to a DNR order. Given the pain and suffering a resuscitation attempt will cause, families will often agree to a DNR order even when they do not agree to limit anything else.