

The Challenge of Futile Treatment

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- **Guest Post by Lindy Willmott and Ben White**

For decades, researchers from around the world have found evidence that doctors provide futile treatment to adult patients who are dying. Some discussion of this topic has turned on matters of definition (see [our recent contribution](#) to this debate), with a broader concept of “perceived inappropriate treatment” being favoured by commentators more recently. However, this debate skirts the fundamental issue: how can treatment that may prolong or increase patient suffering, waste scarce health care resources, and cause distress to health care workers still occur in hospitals around the world? In other words, in these days of overworked doctors and underfunded healthcare systems, how is this still an issue?

Some research has tackled this although it has tended to focus on doctors operating in intensive care units and there has been very little research which looks at the reasons given by doctors from a range of specialties about why futile treatment is provided at the end of life.

[Our study](#), undertaken by a team of interdisciplinary researchers, explored the perceptions on this topic of doctors, from a range of specialities, who are commonly involved with treatment at the end of life. We interviewed 96 doctors at three hospitals in Queensland, Australia, from a range of specialities including intensive care, oncology, internal medicine, cardiology, geriatrics, surgery, and emergency. Doctors reported that doctor-related and patient-related factors were the main drivers of futile treatment, although reasons relating to the institutional nature of hospitals were also important.

We found that doctor-related reasons were important in the provision of futile end-of-life care. Many doctors reported attitudes of their colleagues that reflect a cultural aversion to death. Doctors saw themselves as trained healers who viewed every death as a failure, and pursued a cure rather than appropriate palliative treatment for dying patients. Doctors described wanting to help the patient and not give up hope that a treatment might provide some benefit. They also said they wanted to satisfy patients, families, and medical professionals themselves that everything possible had been done, due to both emotional attachment to the patient and fear of the legal consequences of refusing demands for treatment. They also admitted to providing families and patients with a smorgasbord of treatment options as a means of avoiding uncomfortable conversations about dying. Doctors’ personalities, religious backgrounds, and their own experiences with death and dying were also said to contribute to the giving of futile treatment.

The study also identified patient-related and institutional factors as important drivers of futile treatment and, as such, suggested the need for an attitudinal shift within the broader community to have conversations about death and dying. We also recommended that hospitals need to look carefully at how they operate to ensure that treatment for a curative goal is not the unthinking default.

But here, we want to stress the critical role of doctors individually and the medical profession, and the opportunity to bring about change. First – and we think this is critical – doctors themselves are pointing to their own behaviour as an important factor to be addressed, as well as the way tertiary hospitals currently operate. Doctors are owning the problem, and not just blaming this phenomenon on patient/family demand or the law. Secondly, change will not occur unless doctors are prepared to act and to lead. It is not enough to educate the community about the limits of

medicine or the importance of 'a good death' and so on. Doctors should not be offering treatment that evidence tells us will not work. They should stop ordering routine tests that will not alter treatment or affect patient outcome. They must have the difficult conversations with patients and family instead, notwithstanding how long this conversation may take, or how many times they may have to have it.

This call for action and leadership by doctors does not mean that patients and families are irrelevant and should not be involved in the decision-making process. On the contrary, they need to understand the medical diagnosis and prognosis and what to expect as they or their loved one approaches death. And as [we have argued elsewhere](#), futility is a subjective concept so engagement with patients and families about their values and goals of treatment is essential. As identified by many doctors in our study, communication is the key. And, of course, doctors need to be supported institutionally to do this. Taking the time to have the conversations need to be recognised as part of their day job, and valued as highly as reducing surgery waiting lists or efficiencies in emergency departments.

Are doctors up for this challenge?