

# MEDICAL FUTILITY, END-OF-LIFE CARE, AND OBESITY

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During the 1990s, it was hoped that if we could define futile care, we could agree that physicians were not obliged to provide it.<sup>1</sup> Unfortunately, defining futility proved difficult, and lately, even in instances when futility seems apparent, court decisions have supported the right of patients or their families to override objective medical judgment, and to insist on continued care. As O'Connor notes in this issue of the *Journal*,<sup>2</sup> The Code of Ethics of the American Medical Association, while stating that a physician has no obligation to provide medical treatment that has no reasonable chance of benefitting the patient, still recommends avoiding the concept of medical futility, which cannot be meaningfully defined.

The matter has recently been further explored in two clinical vignettes in the New England Journal of Medicine. In the first, Truog recounts the course of a 2-year-old born with a frontal encephalocele.<sup>3</sup> After neurosurgery left the child neurologically "devastated," the family rejected the recommendation that care be confined to comfort and palliation. After multiple hospitalizations, the child coded in the ICU and full-bore resuscitation was attempted for 15 minutes before he was pronounced dead.

Truog maintains that though "the interests of the patient are always primary, at the end of life there are times when the interests of the patient begin to wane, while those of the family intensify. Family members may live for years with the psychological aftereffects and regrets of end-of-life decisions... I believed that this child was beyond suffering, whereas the psychological needs of his parents were both clinically and ethically significant."

While sympathetic to Truog's sentiments, I strongly disagree for several reasons. First, if we place the family's psychological needs above those of the patient, are we unethically abusing the unconscious patient for the sake of the family? Second, this is an exorbitantly expensive form of psychotherapy. For the cost of a couple of days in a modern ICU plus a full-scale resuscitation, we could assign a psychologist to

this entire family full-time for several weeks. Or, we could use the resources to provide unquestionably beneficial care, such as dialysis, to someone else. One would think that by now everyone has been disabused of the myth that we are the "richest country in the world," with unlimited resources. This discussion would be moot if the family were not isolated from the actual cost of their son's care. Regardless of their finances, would they still insist on exercises in futility?

In the second vignette in the NEJM, a cardiology fellow, and daughter of a physician, recounts her reaction when her demented 90 year old grandmother was admitted to hospital for "failure to thrive."<sup>4</sup> Not eating, dehydrated, and disoriented, she was—in her physician granddaughter's own words, "transitioning to death." Still, her granddaughter abandoned all objectivity and everything she knows about allocation of resources, and wanted "the kitchen sink thrown" at her grandmother. This included a feeding tube and antibiotics. One year later her grandmother is still alive with round-the-clock care, and lives in a delusional world in which she is unaware that her husband is dead. Her granddaughter counts it a triumph that her "Deedee" doesn't "have to ever say goodbye" to the ones she loves, because she doesn't understand that they are dead!

This odd statement implies that delusion is superior to reality. It reminds me of the cartoon in which a psychiatrist is talking to a slightly disheveled patient on the couch and says: "You are completely out of touch with reality. . . . you lucky bastard!"

I don't know if I am more disturbed by the immaturity of this budding cardiologist's lack of embarrassment in displaying her selfishness and poor clinical judgment publicly, or the fact that the New England Journal would publish this paean to irresponsibility. Unfortunately, as O'Connor's article in this issue points out, the courts increasingly support her attitude. The profligate use of resources that results from our unwillingness to withhold futile care will someday soon cause much more difficult and

unappetizing choices. In national debates about health policy, the threat of “death panels” and “rationing” is used as a bludgeon, as if rationing is anathema. But of course, our health care system rations every day. We do so by ability to pay, by socioeconomically determined access to care, by lack of education and consequent ignorance of options, by distance from tertiary care centers, and by empiric decisions made at the bedside without hard data.

The connection between these examples of futile care and obesity is not so far-fetched. Obesity is another example of a condition that is sapping our health care resources because of unwise decisions made by individuals. Further, for most of the morbidly obese, attempts at weight loss are an exercise in futility; sustained weight loss without bariatric surgery is achieved by only 2-20%.<sup>5,6,7</sup>

The intractability of the problem is highlighted by an item in *The New York Times* about New York City’s pioneering law that requires chain restaurants like McDonald’s to post calorie counts.<sup>8</sup> The study, conducted by collaborating investigators at New York University and Yale, tracked customers at four fast-food chains—McDonald’s, Wendy’s, Burger King and Kentucky Fried Chicken—in poor neighborhoods of New York City where there are high rates of obesity. About half the customers noticed the calorie counts posted on menu boards, about one quarter of those who noticed them (i.e. one eighth) said the information had influenced their ordering, and 9 out of 10 of those said they had made healthier choices as a result. But when the researchers checked receipts, they found that people had, in fact, ordered slightly more calories than the typical customer had before the labeling law went into effect, in July 2008.

The obesity problem is so big that even after the last issue of the *Journal* was devoted to it, we could not publish all our material on the subject. In this issue of the *Journal*, Dr. Dise offers a discussion of problems administering anesthesia, many of which are related to the sheer size of the patients—their need for immense operating tables, equipment and doorways. In the community, these logistical challenges are mirrored in the problems faced by paramedics, firefighters, and policemen who must extract and transport the obese with equipment that is not designed for the task, while risking injury themselves from straining with unfamiliar weights. A winch-equipped ambulance capable of handling a 500-pound patient costs upward of \$250,000. According to *The Washington Post*, last year Fairfax, Virginia moved 56 patients weighing more than 400 pounds among its roughly 63,000 EMS calls; Montgomery County fire officials estimated they moved a dozen patients in that weight range among 58,000 transports; and Prince George’s County handled about 100 among its roughly 100,000 EMS calls last year.

Such problems in our community are reflected in Alice Yoder’s description of LGH’s community programs that address obesity; Dr. Alan Peterson has provided a magnificent discussion of the metabolic syndrome in his inimitable style; and Dr. Jeffrey L. Martin discusses the problem of hypertension in the obese.

The current issue is completed by Dr. Cope’s thorough discussion of the use of left ventricular assist devices in acute and chronic heart failure, a program that places LGH in the forefront of community hospitals that offer this technology.

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