StarTribune Editorial

Our perspective

Grappling with futility

What to do when there's nothing to do

In the old days, life was over when the heart stopped beating. That was the time to say a last goodbye and pull a sheet over the body. But these days, cardiac arrest often marks the start of a frenzied dance. Nurses call out, doctors come running. They leap upon the body with their last bit of magic — breaking ribs, dispensing electric shocks, forcing a tube down a quiet throat.

The ritual would be less mystifying if it had some salutary effect. But when administered to those in the advanced states of grave illness, cardiopulmonary resuscitation — like other medical rituals — is most often as futile as it is frantic. As Americans contemplate what they hope for at the time of death, they must think as well about what isn't worth hoping for.

CPR is worth dwelling on because it is held in such unreasonably high regard. Originally developed to restart the suddenly stopped hearts of the otherwise healthy, CPR is now seen as a magic bullet against death. But while CPR can indeed startle an aimlessly quivering heart to its senses, it can't do much of anything for a body succumbing to physiologic collapse.

This is why the numbers are as they are: Many studies show that using CPR on the very sick — patients with metastatic cancer, with advanced AIDS, with failing organs, with extended coma — almost never prolongs life. Even in the tiny fraction of cases in which such a patient is resuscitated, the chance of the patient's leaving the hospital to live a half-normal life is less than 1 percent.

So how has it happened that, in America's hospital wards, CPR has become obligatory? Why is it now expected to be performed on all patients who haven't explicitly said they don't want it?

Drs. Lawrence Schneiderman and Nancy Jecker find the answer in a reflex they call the "technological imperative." In their 1995 book, "Wrong Medicine," they describe a conviction that now governs much of medical thought: If a technique or medication exists, the theory goes, then medicine must use it. Hence doctors find themselves scrambling to revive a stilled heart — whether or not the scramble can succeed or help the patient.

CPR isn't the only pointless, reflex-driven dance being performed these days. The repertoire of futility is vast, and it's hard to distinguish it from the repertoire of healing. Doctors flirt with futility whenever they pick up a stethoscope.

It could be said that futility is an occupational hazard — something that comes with knowing how to save lives. Doctors are wonderfully adept at maintaining the body's proper flow of air and blood, at getting nutrients safely into the body and waste tidily out of it. They can fight off infections, throw poison at cancers and bring errant electrolyte levels back into whack. They can do these things blindfolded, and sometimes it seems that they do.

The results can be seen in every intensive care unit (ICU) in the country, where warding off death is a well-honed habit. Yet Schneiderman and Jecker question the sense in indulging it: "When they were developed in the 1960s," they write, "ICUs were intended to be only temporary havens for desperately ill patients who would be expected either to die or to recover. But today, ICUs have become a kind of purgatory for many patients who remain for months and months on the brink of death before succumbing to their illness. Such patients totally depend on intensive-care medical care for survival in the ICU. Is this a goal of medicine, to sustain life in the ICU?"

Learning to die

Rethinking one's care at life's end

And is it a goal of society, to stave off death at any cost? The dispassionate might say no, but the desperate sometimes answer differently. Yale medical professor Sherwin Nuland, author of "How We Die," notes how easy it is to fall into the futility swamp: "Treatment decisions are sometimes made near the end of life," he writes, "that propel a dying person willy-nilly into a series of worsening miseries from which there is no extrication — surgery of questionable benefit and high complication rate, chemotherapy with severe side effects and uncertain response, and prolonged periods of intensive care beyond the point of futility."

Many doctors don't think twice about treating the pneumonia of a demented 92-year-old or pumping liquefied nourishment into a permanently comatose patient. And even when they think it's wrong, doctors often feel obliged to pursue such treatments — from hooking the terminally ill to ventilators to attempting CPR on frail old ladies who want one last shot.

But doctors should think twice, and they shouldn't feel obliged. Dr. Robert Truog, a professor at Harvard Medical School, argues the point colorfully: "We as physicians are not vending machines. We're not soda-pop machines sitting in the corner from which you can get the treatment of your choice."

Neither is medicine a font of miracles. Sometimes there's nothing a doctor can do to help a patient. When that's the case, it's wrong to pretend otherwise. Defining which treatments are futile is a touchy task, something for both doctors and patients to mull. But they ought to get on with it. Society can't afford a damn-the-torpedoes approach to death, and patients shouldn't stand for it. That kind of delusional thinking is what makes death so arduous and medicine so expensive.

Not that the futility argument is chiefly about money: Most research suggests that limits on ineffective treatments wouldn't save much. But even so, there's something unsavory about a system that guarantees a prolonged ICU death to some while denying a strep check to others.

Richard Lamm, the flamboyant former governor of Colorado, wonders about this: "We are spending millions of dollars on esoteric improvements at the margin," he complains, "while spending pennies on the access problem where we could buy far more health. We give some people too much health care and others too little . . . . We spend incredible amounts of money on kidney dialysis, but practically nothing on educating people to stop smoking and abusing alcohol."

Surely Americans don't want their doctors to shrug off real life-saving opportunities while jumping at the chance to prolong death. Medicine is a communal resource, which is reason enough to object to squandering it. But thriftiness isn't the only — not even the main — reason to resist ineffective medical care.

Doctors should say no to futile heroics because they're pointless, and often cruel, and wrong. When no treatment can be found to aid recovery or extend meaningful life, doctors should rely on a line they've spoken for centuries: "I'm sorry, we've done all we can."