

# Ethical dilemma in the use of nonbeneficial treatment at end of life



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“ Medical futility” is the phrase used to describe the situation in which continued treatment is not beneficial to the patient and, therefore, should not be used. However, because what is considered futile is different for each person, the issue of medical futility is subjective and, consequently, the definition can be viewed in different ways. One way to view medical futility is that there are no physiologic benefits for the patient that treatment can provide, and another view is that there is no benefit to the patient’s overall goals of comfort at the end of life. Nonbeneficial treatment is futile treatment as it does not produce effects that are beneficial to, improves the quality life of, or accomplishes the goals of the patient. This ethical issue asks the question, “ Would continued treatment for a patient at the end of life truly follow the ethical principles of autonomy, nonmaleficence, beneficence, justice, and fidelity?”

Cardona-Morrell, Kim, Turner, Anstey, Mitchell, and Hillman (2016) researched nonbeneficial treatments in hospitals at the end of life internationally in 10 different countries, including the United States, and found that about 33-38% of patients at the end of life received nonbeneficial treatments. These numbers show that the issue of nonbeneficial treatment given at the end of life is prevalent internationally as well as in the US. Patients themselves are affected by the use of nonbeneficial treatment. However, the family members and the care providers who need to make decisions on when treatment is no longer ethical also face this dilemma and can become emotionally and mentally distraught. Between the patient, the family members, and the health care providers, each can have differing opinions on whether to continue treatment and do everything necessary to

keep the patient alive or to end the treatment and provide for a comfortable end of life. In the end, decisions made by the patient, health care provider, and family members can lead to a lower quality of life at the end of life.

### Literature Review

Cardona-Morrell et al. (2016) researched the extent of which nonbeneficial treatments were used at the end-of-life, more specifically in the last six months of life. Their research found that there is a significant amount, 33-38% of patients, of use of futile treatments near the end of life (Cardona-Morrell et al., 2016). Cardona-Morrell et al. (2016) found that physiologic futile treatments such as dialysis, transfusions, and life support was prevalent in about 7-77% of patients while chemical futile treatments such as medications and antibiotics occurred in 11-75% of patients. In addition, chemotherapy at end-of-life was used for 33% of patients while nonbeneficial admission to ICU occurred for 10% of patients nearing end-of-life (Cardona-Morrell et al., 2016). Cardona-Morrell et al. (2016) found that chemotherapy at end-of-life, ICU admission at end-of-life or for incurable/terminal disease, and life-sustaining treatments for patients with DNR code status are all indicators of nonbeneficial treatment.

In a life-or-death situation, health care providers and family members are forced to make decisions that may result in nonbeneficial treatment of the patient due to popular beliefs about life and survival being the most important end outcome. However, these decisions only push off the inevitable while being unable to guarantee a better quality of life, even if it is a longer life, and making for a more difficult and sometimes even a more

torturous end-of-life experience. Coming to terms that this route of thinking is not the best is important as the elderly population increases. The use of nonbeneficial treatment needs to be reduced in order to reduce burn-out felt by health care providers, false hope in life for patients and family members, and the thinking that death means failure to treat (Cardona-Morrell et al., 2016).

The dilemma, however, is that the definition of nonbeneficial, or futile, treatment is ambiguous. In addition, there is no clear answer as to who decides when treatment is futile and at what point treatment should be considered futile. While it may be considered futile for a person with a terminal illness to be treated, what about the patient who experienced a sudden fatal condition? Would it still be considered futile to treat that patient even knowing that their chance of survival is near zero? Cardona-Morrell et al. (2016) emphasizes a need for a decision-making model as to when ICU admission or treatments should be considered futile. There are different perceptions of futility between different health care providers and, when factoring in family members, there are too many opinions which hinder good decision-making.

The research conducted by Neville, Wiley, Yamamoto, Flitcraft, Anderson, Curtis, and Wenger (2015) studied the differences between nurses' and physicians' perceptions and evaluations of futile care. They investigated reasons why the treatment should be considered futile and the outcome of the patients who received such treatment through surveys that both nurses and physicians have assessed on the same day (Neville et al., 2015). For the most part, nurses and physicians perceived about the same number of

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patients as receiving futile treatment (Neville et al., 2015). However, Neville et al. (2015) found that there was some discrepancy between patients that nurses believed were receiving futile treatment and patients that physicians believed were receiving futile treatment, with physicians categorized 113 patients to be receiving futile care compared to the 110 patients categorized by nurses.

In addition, Neville et al. (2015) found that patients perceived to receive futile care had a higher mortality rate within six months than patients receiving non-futile care. The patients that physicians assessed to be receiving futile care had a higher mortality rate than those assessed by nurses (Neville et al., 2015). Intriguingly, patients thought to be receiving futile care by both nurses and physicians were the most likely to die in the hospital than the patients assessed to be receiving futile care by the nurse or the physician alone (Neville et al., 2015). This result is noteworthy since it discovered that the decisions by the health care providers to either provide or give up treatment was not the only factor that could affect the patients' outcomes; the concordance between the nurses' and the physicians' perceptions of futile care could also be a significant predictor of the outcome of the patient (Neville et al., 2015).

## Discussion

It is important to keep an eye on the difference in perception of futile treatment between nurses and physicians in order to determine why nurses and physicians make different decisions regarding end of life care. In this regard, I believe that the most important is to first have a fixed definition for

futility in health care based on the ethical principles of respect for persons, beneficence, nonmaleficence, and fidelity. In addition, Katharine Kolcaba's Theory of Comfort can be applied to end-of-life situations to help nurses.

### Ethical Principles

Nonbeneficial treatment, or medical futility, is related to the ethical principles of respect for persons, beneficence, nonmaleficence, and fidelity. The ethical principle of respect for persons refers to the treatment of patients in a respectful, valued, and dignified manner while giving the patient autonomy in understanding and making their own informed choices (Giddens, 2017). As the nurse, it is important to remember that the patient is a human being who should be able to decide how they want to be treated at the end of life. The dilemma is deciding when the patient's choices may not be in his/her own best interests.

Beneficence is the principle to act in the best interest of the patient (Giddens, 2017). However, it is difficult to decide what the best course of action is when the patient may want to continue a treatment that significantly lowers their quality of life. In addition, the decision that death may be in the best interest is a difficult to not only accept but to explain and support. The principle of nonmaleficence plays a big role in this difficulty since nonmaleficence encourages us to act in ways to avoid harming others (Giddens, 2017). As Cardona-Morrell et al. (2016) states, " Admission to an acute hospital and prevention of death through clinical interventions are often the default position whether a patient has a reversible component to their disease or whether they are at their natural end of life" (p. 462). People

assume that pain and death are the worst outcome and subsequently have patients go through nonbeneficial treatments to prevent the outcome they perceive to be the worst—death.

The difficulty for nurses on deciding whether to go through with the treatment can be seen just by looking at these ethical principles. For example, the finding by Neville et al. (2015) that physicians' assessments of perceived futile care corresponded to higher mortality rates in patients receiving the futile care may be because physicians are the ones to give or withdraw the treatment. Physicians may look at futile care as something more objective in which the patient does not benefit from treatment and make decisions looking solely on such data and assessments. On the other hand, nurses had a lower accuracy of predicting mortality rate based on perceived futile treatment of patients (Neville et al., 2015). It could be inferred that physicians have a more detached stance and decide whether treatment is futile based on whether the treatment has a productive outcome and can then either provide the treatment or not. On the other hand, nurses may be more compassionate, resulting in the decreased relation of their assessment and the outcome of the patient. Nurses look at the patient holistically and consider whether the patient is suffering, whether the treatment is worth the suffering, whether the quality of life was lowered to beyond the levels that human dignity should be lowered, and whether the patient wanted the treatment even if futile. If the treatment resulted in the suffering of the patient, even if it was helping in prolonging his/her life, the nurse may determine the treatment to be futile. In that line of thinking, I believe that nurses may consider a treatment to be futile if the suffering at

the end of life is too much or a good quality of life is not guaranteed after treatment.

Knowing the dilemma between nonbeneficial treatment and its potentially negative effects versus ending clinical interventions to provide a more comfortable end-of-life, the nurse needs to follow the principle of fidelity to the patient and his/her decision. Nurses may have several parties that they feel loyal to, whether it is themselves, the patient, other healthcare professionals, or the patient's family (Giddens, 2017). However, nurses have a role in keeping their promises and doing what is expected of them and advocating for the patient. They, as nurses, need to remember that they need to professionally and trustworthily perform their duties to the best of their abilities despite what others may demand or require.

#### Kolcaba's Theory of Comfort

Katharine Kolcaba's Theory of Comfort provides a framework for care based on individualized holistic comfort as an outcome of care ("Kolcaba's Theory of Comfort," 2016). At the end of life, comfort is essential as it can help soothe the patient and prevent or relieve pain or discomfort. According to Kolcaba, there are three types of comfort—relief, ease, and transcendence ("Kolcaba's Theory of Comfort," 2016). The patient feels a sense of relief when their individual comfort need is met, is at ease when they feel calm or content, and is in a state of transcendence when they are able to rise above their discomforts ("Kolcaba's Theory of Comfort," 2016). In addition, the theory emphasizes physical (physiologic comfort), environmental (comfort in their surroundings), psychospiritual (comfort in their identity and behaviors),



and sociocultural (comfort in their social interactions and relationships) comfort for patients and families (“ Kolcaba’s Theory of Comfort,” 2016). By giving comfort to patients in those four domains, they could be more likely to engage in health-seeking behaviors, which are behaviors of a patient to improve his/her health or well-being (“ Kolcaba’s Theory of Comfort,” 2016). In the case for patients experiencing end-of-life, this might include being able to spend time with their loved ones and expressing their wishes. Ultimately, seeking a good death could be considered a health-seeking behavior since a good death signifies that the patient felt peaceful and comfortable in their death. This transcendence to understanding their condition and feeling peace in death could be the best outcome for those receiving futile treatment. At the same time, however, the definition of a “ good” death is also subjective and relates back to what should be considered nonbeneficial treatment.

## Conclusion

The use of nonbeneficial treatment is a serious ethical dilemma in the healthcare field that can be caused by numerous factors, including communication errors, family pressures, legal issues, conflicts of interests/decisions between different healthcare providers, and more. In fact, Cardona-Morrell et al. (2016) reported that 73% of nonbeneficial treatments were caused by demands by the family, 19% due to communication issues, 5% were due to legal concerns, and another 2% due to conflicts between specialist teams. As Neville et al. (2015) has found, agreement between nurses and other healthcare providers on which patient is receiving nonbeneficial treatment can be a significant predictor of mortality in those <https://assignbuster.com/ethical-dilemma-in-the-use-of-nonbeneficial-treatment-at-end-of-life/>

patients receiving nonbeneficial treatments. This means that further collaboration and communication between nurses and other healthcare providers when assessing patients may help to determine which patients need end-of-life care earlier than others.

Collaboration between health care providers, specialists, patients, and family members can help develop a stronger decision-making model regarding end-of-life care that can improve patient care overall, especially at the end of life. If this decision-making model takes into account the ethical principles of respect for persons, beneficence, nonmaleficence, and fidelity and is presented by health care providers using Kolcaba's Theory of Comfort, patients and family members may have an easier time accepting and coping with the situation. While it is understandable for some nonbeneficial treatment to exist to alleviate the worries of family members or possibly make patients more physically comfortable at their end-of-life, medical futility and the use of nonbeneficial treatments need to and should be reduced.

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