

QUESTION

When does treatment in cancer care become futile?

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Futility in medicine has been defined as excessive medical intervention with very little prospect of altering the clinical outcome in a positive manner (Schneiderman, 2011). If treatments fail to release our patients from the preoccupation with the illness and do not allow them to pursue their life goals, then perhaps that treatment is futile.

As a nurse, I often lament decisions made by families and physicians. I wonder if patients fully understand the picture of their situation and have enough time to dedicate to exploring all options and ramifications. Often, choices are made that will not be curative and may actually adversely affect the quality of life for the patients. This includes the false hope that patients may gain more time to live.

In oncology clinical practice, efficient and honest communication does not always occur between physicians and patients. Do we stop curative care, and when? What are the benefits of palliative and hospice care? When is it appropriate for patients to seek more treatment, and when is it perhaps not? Physicians may recommend more treatment for patients when the likelihood of survival is low. The quality of life may not match the patients' life goals.

Many of these treatments (e.g., chemotherapy, radiation therapy, stem cell transplantation) can leave patients confused, debilitated, and unable to breathe, eat, or urinate on their own. I see this often, and it can be very discouraging for everyone involved. How many of our patients need to be exposed to seemingly unnecessary chemotherapy and procedures before we say that it is enough? Family members may have a hand in delaying the inevitable because of their difficulty in letting go. As an oncology nurse, I witness this process, often question the plan, and give input that may or may not affect the plan-of-care de-

isions. This includes explaining benefits and risks of therapy and impact on prognosis and quality of life.

Unfortunately, in today's cost-cutting medical environment where time spent with patients is more limited because of time constraints on providers and the desire to maintain a level of profitability, the time spent with patients by physicians is extremely limited. It is refreshing to note that physicians are no longer given incentives to give more chemotherapy that may be ineffective to patients (West, 2011). The time spent by physicians with patients allows for in-depth, quality discussions about the patients' goals. For their care, some patients may not want extreme measures. Our youngest patients may not actually wish to receive extreme measures either.

Ultimately, the process is best served by shared decision making. This means that decisions should involve the patient, family members, and members of the care team. I feel that patients deserve to have a strong say in their care plan. As a hematology bone marrow transplantation nurse, I suggest that time is better spent focusing on the business of dying rather than futile treatments. This entails emotionally preparing for the end of life and making practical decisions. The main plan of care goals can minimize discomfort and pain, allowing family and friends to express love, and give them realistic control over the end of life. In the end, I think this would make dying a more compassionate, just, and honest part of patient care.

RESOURCES

- **Hastings Center**
Discusses aging, chronic conditions, and end of life
<https://bit.ly/2stVwKt>
- **Last Days of Life (PDQ®)—Health Professional Version**
Provides clinicians with information about anticipating the end of life
<https://bit.ly/35lj4yd>
- **National Cancer Institute**
Offers information to help patients cope with the changes that come with a diagnosis of advanced cancer
<https://bit.ly/2ucl1QU>

REFERENCES

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KEYWORDS

palliative; end of life; futility; cancer treatment; shared decision making; patient goals

DIGITAL OBJECT IDENTIFIER

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