Medical Futility

Basically, medical futility refers to treatment thought to be ineffective, medically harmful, or highly inappropriate.

Medical care is often expensive, intrusive, and painful. Serious side effects, such as death and loss of function, may occur, especially in highly invasive treatments. For these reasons, providing inappropriate medical care is morally suspect.

Take note of the word "inappropriate" in the previous paragraph. When is medical care inappropriate? Disputes over whether a treatment is inappropriate are at the heart of the controversy surrounding use of the term medical futility. A treatment one person, perhaps a health care provider, considers inappropriate may be thought by others, say family members of a dying patient, to be highly desirable and inappropriate to withhold. For example, keeping a patient alive for a few hours or days may be considered appropriate by a family member and at the same time may be considered inhumane by a health care provider.

The typical case of a problem involving futility involves health care providers who believe a treatment inappropriate or medically futile while the patient's family members insist on continuation of aggressive treatment.

Concern about providing futile or medically inappropriate treatment goes back to the ancient Greeks. A statement attributed to the Hippocratic tradition points out that health care providers have a moral obligation not to treat when treatment is futile: "Refuse to treat those who are overmastered by their disease, realizing that in such cases medicine is powerless."

When is medicine powerless?

The problem is that medicine may be powerless in one sense and not powerless in another. For example, a patient without any higher brain function -- a patient without human consciousness -- might be beyond cure. However, medical intervention may be able to keep the patient alive, indefinitely, on artificial life support, perhaps a ventilator and medically provided nutrition and hydration. In such a situation medicine is powerless to provide a cure but effective in terms of artificially maintaining physical function.

Some people might consider futile any medical intervention to maintain the life of a person in a persistent vegetative state. Others might believe that preserving the patient's life, even without higher brain function, is respectful and morally required. Such problems begin to indicate why the term futile has generated much controversy.

Question. You say that treatment might keep someone alive who has no higher mental functioning. Isn't that person already dead?
Answer. Some bioethicists claim that people who lack higher brain function are dead, at least as persons, because they no longer have the capacity to think or feel in the way humans do. Higher mental functioning makes us the human beings we are. However, at least legally speaking, someone who does not have higher brain function but has some brain stem activity is not considered dead. A person who loses all brain activity is legally dead in the United States. So at least in a legal sense, a person in a persistent vegetative state is not dead. Also, many people believe that morally speaking such a person is not dead.

Another problem arises based upon the fact that it is often difficult to predict the effectiveness of medical treatment. A treatment thought to have less than a 1% chance of success might actually have, for a given patient, a high probability of success, perhaps a 20% chance.

Suppose a treatment has a very low probability of success. Is that treatment medically futile?

What does a "low probability" of success mean?

Is a one 1 out of 10 chance a low probability? Or should we think 1 out of 100 chance of success is a low probability? Can we talk about a "low probability" without talking about what is at stake?

For example, a low probability of improving a physical function is one thing, while a low probability of saving a life is different. We may think that a one 1 of 10 chance of improving bodily function is not worth it, but a 1 out of 10 chance of saving a life may be thought to be fully worthwhile.

The dictionary definition of *futility* emphasizes uselessness. *Futile* is defined as an action that does not produce results, that is, an action that is not wise to pursue. Futility is the quality of being *futile*. A useless action is one that is unable or highly unlikely to achieve desired goals and is thus destined, at least with a high probability, to fail.

Failure and uselessness are typically related to goals. It is not the case that failure along indicates that an activity involved futility. Instead failure against overwhelmingly bad odds is often labeled futile. A person attempting to high jump over a 12 foot bar might be engaging in a futile action. But that same athlete attempting to jump over a 7 foot bar might have a good chance at success. His or her action would not be considered futile even if he or she failed. A medical procedure which fails is not necessarily futile simply because it fails.

Failure is related to a goal. A person attempting to do a logic proof well beyond his or her skill might not be engaging in a futile action if the attempt is simply designed to pass time or to get accustomed to working with logical symbols. With different goals an action performed by one person may be considered futile while a closely similar act by another person may not be considered futile.
Question. What kinds of treatments might be considered futile?

Answer. When people first started debating the idea of futile care, perhaps in the early 1980s, the main concern was with responses to cardiac arrest, such as CPR. Today many treatments are at the forefront of talk about medical futility, including artificial nutrition and hydration, kidney dialysis, antibiotics, and chemotherapy.

In bioethics *futility* is given several distinct meanings based upon treatment circumstances and goals for treatment.

1. **Physiologic or Strict Futility**

   Some treatments may simply not work in terms of their typically intended purposes. In such cases, the treatment is called *physiological* or *strict futility*.

   CPR on a dead person will not revive the person and is thus strictly futile.

   Typically, physiologically futile treatments need not be performed nor are they expected. The dispute about futility does not typically center on physiological futilely.

2. **Quantitative Futility**

   Given uncertainties in health care, treatments might have a very low probability of success. The chance of success might be low, yet there may be some chance it will work. This would not be a case of strict futility.

   If the odds of success are very low, the treatment may be considered to be *quantitatively futile*. For a treatment to be quantitatively futile, it must have an unreasonably low chance of success.

   The quantitative definition of *futility* requires that we specify the level at which a chance of success becomes unreasonably low. As you might suspect, this is controversial.

3. **Qualitative Futility**

   The final definition of *futility* is the one that most directly involves the purpose of treatment.

   Some treatments might work, or at least have a reasonably good chance of working, yet the goal pursued may be thought to be improper. For example, a goal of prolonging life may leave an incompetent patient suffering from advanced dementia with nothing but misery. Although the patient may be kept alive, health care
professionals may think that the outcome is excessively harmful to the patient.

When the goals of the patient or a patient's surrogate are thought to be medically inappropriate, the treatment requested might be considered *qualitatively futile* by health care providers.

Mrs. Helga Wanglie, an 86 year-old woman in a persistent vegetative state (PVS), was being kept alive on a ventilator. Her husband believed that she might some day recover consciousness but understood that her physicians did not believe this to be a realistic goal of treatment. The health care team was convinced that her care was futile, given that she would never recover, and sought to have the ventilator removed. Mr. Wanglie refused to give permission to remove life-support. The health care team tried to have Mr. Wanglie legally replaced as Mrs. Wanglie's surrogate decision-maker.

A court determined that Mr. Wanglie was the most appropriate surrogate. The court did not consider whether Mrs. Wanglie's treatment was futile.

The conflict in this case is between the view of the health care team, which believed that life-support for Mrs. Wanglie was futile, and her husband, who believed she could improve and that her care was appropriate, even perhaps demanded by God.

The case of Higla Wanglie involves a patient in a PVS. Some bioethicists argue that prolonging the life of such a patient is futile. L. Schneiderman, N. Jecker, and A. Jonsen believe that in many cases there is legitimate dispute over whether or not care is futile, but that when a person is in a PVS, treatment to prolong life is futile.

Schneiderman and his colleagues believe that the only legitimate (non-futile) purpose of medical treatment is to benefit the patient as a whole. Merely keeping alive a person who has no hope of regaining consciousness goes against the purpose of medical care, to provide benefit, and is therefore futile. They say that medical nutritional support for a person in a PVS is "futile for the simple reason that the ultimate goal of any treatment should be the improvement of a patient's prognosis, comfort, well-being, or general state of health. A treatment that fails to provide such a benefit - even though it produces a measurable effect - should be considered futile."

In their view provision of comfort care is not futile provided that the patient actually gains comfort from the care.

As we shall see, the position of Schneiderman, Jecker, and Jonsen is controversial.

Another case frequently referred to is that of Baby K. Baby K was an anencephalic infant born in 1992.

At birth, Baby K's life was artificially maintained; eventually she was weaned from the ventilator. Hospitals in the Fairfax Washington area did not want to treat Baby K, so at 6
weeks of age Baby K was transferred to a nursing facility. She was readmitted to hospital care several times due to respiratory problems.

Fairfax Hospital requested that a court appoint a guardian to make medical decisions about the care of Baby K. The appointed guardian agreed to permit cessation of aggressive treatment.

This decision was problematic because a United States federal law, the Emergency Medical Treatment and Labor Act (EMTALA), establishes that people typically have a right to emergency care. The law calls for medical stabilization in emergency situations. The hospital agreed that respiratory distress was an emergency condition, but argued that that care was futile, and thereby not covered under EMTALA. However, a higher court required ventilator support when needed by Baby K. During her short life, she spent many days undergoing treatment in a pediatric intensive care unit.

Schneiderman, Jecker, and Jonsen claim that "No ethical principle or law has ever required that physicians to offer or accede to demands for treatments that are futile." They further claim, correctly, that Baby Doe regulations do not require treatment of an infant when treatment is virtually futile.

Schneiderman, Jecker, and Jonsen would agree that the treatment of Baby K was futile because it did not provide the baby with any benefit that the baby could appreciate. Nevertheless, treatments kept Baby K alive, and were, as the court declared, required under EMTALA. The Court in effect affirmed the notion that Baby K is a living person who has a right to treatment under EMTALA. The treatment worked in the sense that Baby K was helped to live for several years.

Apparently, Baby K's mother believed that the treatment was helpful. The Court held that the fact that Baby K was in a PVS did not itself support termination of emergency treatment.

Howard Brody, a well known bioethicist, claims that the term futility should not be applied to either of the cases we have covered: Hilga Wanglie and Baby K.

In both of those cases, the treatment did what it was designed to do, maintain life. Brody claims that "the basic, commonsense notion of futility (however difficult it may be to define in detail) [means] that an intervention will not work, within reasonable certainty." Simply stated, these treatments worked. Because the treatment worked, the question then centers on the proper goal of treatment. This is not a matter, says Brody, which rests within a physician's proper skills. "It seems much more securely within the professional expertise of the physician to say whether a particular intervention will promote an identified goal than to say whether a goal is worth pursuing."

A situation involving genuine futility, according to Brody, would be one in which a patient's surrogate insisted on treatment that would not work. For example, family members, wanting a genuine cure, may demand treatment only designed to prolong life
but not to cure a person in a PVS. However, if instead they desire life-prolonging treatment, Brody would not view the treatment as futile.

L. Schneiderman answers Brody by reasserting that in the Wanglie and Baby K cases, life-sustaining treatment serves no legitimate medical purpose. Health care professionals are obligated to provide health benefits. To practice in a way that does not provide such benefits is to engage in a futile effort.

If the provision of medical benefit is at the heart of making the determination that care is futile, then health care professionals should be the ones that are best able to make the judgment.

Some bioethicists believe that if physicians decide what counts as inappropriate treatment that this basically deprives patients of their rights. For example, the bioethicist Charles Weijer views "medical futility" as an attempt to breach patient autonomy. He says: "Medical futility is designed … to be a trump card for physicians."

To support his view, Weijer disapprovingly cites Schneiderman, Jecker, and Jonsen: "Futility is a professional judgment that takes precedence over patient autonomy and permits physicians to withhold or withdraw care deemed to be inappropriate without subjecting such a decision to patient approval."

Nevertheless, Weijer believes that patients have no unilateral right to medically inappropriate care. When physicians conclude that care is inappropriate, they should engage in dialogue with patients or their surrogates.

In the previous frame we learned that Charles Weijer believes use of medical futility is an attempt to place physician decision making in a primary place, in effect trumping patient oriented decision making. He believes that withdrawing aggressive treatment should be done in consultation with patients and/or proxy decision makers.

L. Schneiderman disagrees. Based on the experiences of physicians, some treatments are known to be futile. Physicians have no obligation to provide or offer such futile treatment. In effect, physicians are the only ones who have the expertise to determine whether or not a treatment is futile.

This expertise might be extended to other members of the health care team. Nurses, for example, often know that a patient will soon die and that aggressive treatment is not going to provide meaningful relief.

Please read the case of Mr. Q. It involves circumstances similar to those that often that lead health care professionals to claim that treatment is futile.

Mr. Q.
76 year old Mr. Q suffered from multiple system failures, involving his kidneys, lungs, and heart. He lost over 100 lbs and had little reaction to stimuli. A nurse observed that
she had never seen a living patient look so much like he was dead. Mr. Q's physician, Dr. D, acted as though he believed Mr. Q would recover based on the fact that he continued aggressive treatment including dialysis, heavy doses of antibiotics, as well as drugs to keep Mr. Q's vascular system working by correcting his extremely low blood pressure. Mr. Q had a full code, so if he experienced cardiac arrest, everything would be done to revive him. Mr. Q was also on a ventilator. One nurse, Ms. T, thought that such treatment was inhumane or at least medically inappropriate. She called the treatment "futile," and thought that Mr. Q should be allowed to die with dignity. She strongly believed that palliative care was the only appropriate treatment for Mr. Q, and that his family should be notified about the lack of appropriateness of aggressive treatment. Ms. T felt so strongly about this that she called the bioethics department at her large urban teaching hospital, hoping that someone would talk Dr. D into doing what she believed was the right thing, offer palliative care to Mr. Q's proxy, his wife. The bioethics consultant gathered information and started talking to members of the healthcare team. The ethics consultant made an appointment with Dr. D for the following day, but before the appointed time, Mr. Q died.

Whether or not a person will respond to a medical treatment is often not known with certainty. Instead there might be a known chance or probability that the patient will not respond or that a patient is likely to die soon. This may be based on evidence from studies or clinical trials, or may be based on the experience of a physician, perhaps in consultation with medical colleagues.

When a treatment has a low probability of success, quantitative futility is involved. The question is: How low must the probability of success be before the treatment is considered futile or medically inappropriate?

Some bioethicists believe that if the probability of success of a treatment is only five percent, then the treatment is futile.

Some bioethicists believe that a treatment response rate of less than 10 percent is medically inappropriate. However, in life or death situations, that would mean that many people would die without treatment who would have lived with treatment.

In life or death situations, a five percent chance of survival would appear significant and worth the try to many people. In fact, many cancer patients accept participation in phase I clinical trials where the probability of a significant response, perhaps a significant reduction in tumor size, is about five percent. Many patients agree to participate in such trials even after they are carefully informed about the purpose of the trial. They often hope it will save or prolong their lives.

A five percent change is a good reason, to many patients, to accept treatment. Health care professionals may have more experience with reactions of patients after such treatments, but still the value system of the patient is crucially important in determining whether the expected success of the treatment is worth the costs. Keep in mind that treatments often involve serious risks and painful side effects.
Question. Not working in the last hundred cases sounded like a good standard indicating that there would be little chance of it working. However, as you went on, it became clear that not working in the past 100 cases is consistent with it working 3 times out of one hundred. That sounds like better odds to me. If I were facing a sure death without a treatment, and life with a 3% chance, I would select the treatment that Schneiderman and his colleagues would call futile.

Answer. First of all, the treatment might never work if based on the past experience that it hasn't worked in the last 100 attempts. Not working in 100 cases is pretty bad. It probably won't work the next time, at least if all these cases are very similar. But we can't be certain. We do have very good reason to believe that it will not work in at least 97 out of 100 cases.

Your point is well taken. There is still a chance the treatment might work. Who is to make the decision about whether such a treatment is futile or inappropriate? Some bioethicists have criticized the 100 past cases standard for another reason. They claim in effect, that 100 similar past cases are rarely, if ever, available for comparison. Remember also that such treatments typically come at high cost, both in terms of monetary expense and in terms of side effects and patient suffering. So when the odds of success are very low, accepting such suffering may appear unreasonable, even with a 3% chance of success.

Health care professionals may react to demands to provide resuscitation, such as CPR, by deceiving patients and their families into believing that full resuscitation will be provided. Actually they may respond in a "slow" or ineffective way in order to avoid complete resuscitation. By acting slowly, the patient is much more likely to die. This is called a slow code.

Most bioethicists would probably agree that a slow code is morally unacceptable at least due to its deceitful nature.

A "partial code" may be written, with the agreement of the patient or family members, to the effect that some forms of resuscitation are appropriate while other forms may not be. This is morally acceptable. But often resuscitation is difficult and so any limitations might ensure failure.

Futile treatment is a serious problem because frequently families of patients request or demand treatment the health care team believes is inappropriate. Many cases involve patients with multiple system failure, often heart, lungs and kidneys. A terminal cancer diagnoses may also be involved.

While it may be apparent to the health care team that aggressive treatment will do little but prolong the patient's suffering, family members sometimes see it differently. They want everything done, even if it extends life for even a few days or hours. They may not believe the health care team is telling them the truth. Against the odds they may think
that there is a chance for a fuller recovery, with the patient returning home, at least for some period of time.

Family members may be correct. For example, a standard of futility involving failure in 100 past cases similar to the current case is difficult to apply given the variety in types of problems patients face: different organ systems affected in different ways, different diseases causing problems, and so on.

Health care professionals are often accurate in recognizing that patients are close to death and that further aggressive treatment will not work. Treating patients in ways thought to be inappropriate is often emotionally and professionally stressful to health care professionals.

Often members of the health care team find it discouraging or even inhumane to treat patients where the cost to treatment seems to far outweigh the benefits. For example, continuing chemotherapy for a lung cancer patient, without real hope that it will extend the patient's life, means, in all likelihood, that the treatment seriously harms the patient, going against a primary responsibility of a physician to avoid doing harm.

Hospital policies dealing with non-beneficial treatments can help health care professionals to resolve such problems.

In the following frames, we examine the American Medical Association's recommendations about medically inappropriate treatment as well as a widely mentioned policy in current Texas law. These offer processes designed to deal with disagreements between patients and/or their proxies and their physicians.

Question. I think that concern over futile treatment is overdone. Very often the patient in question dies soon, or doesn't really know what is happening, as in the case of PVS. So the patient isn't really suffering too much from futile treatment. In other cases, the patient demands treatment. Even though the treatment doesn't work, it is what the patient wants, so it can't really hurt the patient. So why not just provide what patients or their surrogates want?

Answer. I don't think it is as easy as you make it. First of all, there is an issue about the integrity of the medical profession. Many professionals, including music composers and architects, object to using their skills in a way that is inappropriate. Teachers don't want to teach in a way that does not promote learning, or worse, may do the opposite, even if that is what students want. Some treatments harm patients even though patients or proxies think the treatments will help. For example, unhelpful chemotherapy has harmful side effects, perhaps life threatening. And, to bring up an economic issue, continued unnecessary care is expensive, sometimes depleting the resources of family members. From a moral point of view, the issue tends to revolve around the fact that inappropriate treatment is often harmful, perhaps inhumane, even when it is demanded.
The American Medical Association's Code of Ethics contains an opinion entry on futility in End-of-life care (E-2.037 Medical Futility in end-of-Life Care). The AMA's policy is prefaced by asserting an obligation to move from aggressive treatment to comfort care and closure when intervention intended to prolong life becomes futile. However, it is recognized that the determination that care is futile involves value judgments. Thus, careful consideration should be given to the values of patients or their surrogates concerning worthwhile outcomes.

Since conflicts between health care providers and patients and/or their proxies may persist after consultation, the AMA recommends that all health care institutions should have in place a futility policy.

Such policies should include a series of steps involving, first of all, an attempt to negotiate a joint decision. If disagreements persist, then a committee, perhaps an ethics committee, should become involved. If the committee supports the patient's view, then treatment should be switched to another physician if the attending physician continues to refuse to provide aggressive treatment. If the committee supports the physician's view, and the patient or his or her proxy remain insistent, then an attempt should be made to transfer the patient to another hospital. If transfer is not successful, treatment would not be required.

A current statute in Texas provides a legally sanctioned procedure that is similar to the AMA Guidelines. It comes into play when a physician refuses to honor the treatment demands of a patient or his or her proxy.

An ethics or medical committee, on which the physician may not serve, reviews the case after giving adequate notice to the patient/proxy about the review and offers an invitation to the patient or proxy to attend the meetings. The patient or proxy is entitled to receive a written explanation of the decision that the committee reaches.

If either the physician or the patient or proxy does not agree with the committee's decision, then the physician should make a reasonable effort to find another physician, perhaps at a different facility, who would agree to provide treatment. The law stipulates that if life sustaining treatment is at stake, and if the committee agrees that it is inappropriate, the treatment will continue while efforts are made to transfer the patient. Nevertheless, if no alternative care is found, then after 10 days the treatment in question may be withheld provided a court does not extend the period in order to find alternate care.

Demands for treatments that are futile or inappropriate might be confused with patient autonomy. Technically, autonomy in informed consent refers to the acceptance or rejection of treatment that is medically appropriate. A patient has no right to inappropriate treatment. The trouble revolves around disputes over what counts as futile or inappropriate treatment. For an example, link to the case of Sonja Pines.
Ms. Sonja Pines, an 83 year old who suffers from liver cancer and kidney failure, is no longer able to communicate medical decisions. Her 60 year old daughter, Sarah is recognized as her proxy. The health care team believes that CPR is inappropriate for Ms. Pines and that kidney dialysis should be discontinued. In a few days, or perhaps a few weeks, she will almost certainly die. She is quite frail, so CPR would probably produce significant damage and is unlikely to be successful. If she survived CPR she would probably be brain damaged. A resident, Dr. Patik, talked with Sarah, who adamantly insisted that "everything" be done for her mother. Her family members mostly live out-of-town and rarely visit. They all agreed, Sarah said. The resident call for an ethics consultation, but before there was a response, Ms. Pines coded and CPR was performed. The procedure caused two broken ribs; although Ms. Pines was not able to communicate, it appeared that she suffered as a result of the CPR. She was placed on a ventilator. Dr. Patik thought that the results of the CPR confirmed the view of the health care team about the harmfulness of the procedure. Sarah believed, with good reason, that her mother would have died without resuscitation. A bioethicist began investigating and called for a meeting between the health care team and Sarah. All parties continued to maintain their respective positions, sometimes in a fairly heated way. The bioethicist decided to call a meeting of the hospital ethics committee, but Ms. Pines died, three days after CPR.

One unfortunate thing about the case of Ms. Pines is that her view on whether "everything" should be done was not heard. She had no genuine awareness of her final days, with the real possibility that she died after experiencing some pain. Can such situations be avoided?

Question. I understand that many cases occur in which a family asks for care that is thought to be inappropriate or harmful by the health care team. I've heard of cases that were truly tragic, where additional aggressive care seemed to me to be inhumane, for example painful chemo for a person in advanced stages of dementia. If aggressive care is obviously inappropriate, why is it provided when health care professionals are neither morally nor legally required to do so?

Answer. Very often care is continued, but sometimes it is not. The reasons for continuing care are varied. Physicians have different views on the appropriateness of care, which seem to be correlated to various traits of physicians, such as age, race, and religious background. Also keep in mind that health care professionals and hospitals do not want to unduly anger family members, partly out of fear of lawsuits, which, whether successful or not, are costly. Sometimes the law is not clear on whether continuation of treatment is required. A procedure like the one in Texas is very time consuming and infrequently used. The best answer is to have all parties agree about proper treatment.

Discussions about end-of-life care are often postponed until death is near and it becomes obvious to health care professionals that aggressive treatment is futile. At that point, views on both sides are sometimes already entrenched and difficult to change.

The earlier communication over appropriate treatment begins the better.
Patients should be encouraged to have advance directives even before they have serious health problems.

Communication about end of life decisions is primarily the responsibility of the attending physician, but another person, such as a nurse or bioethicist may be more appropriate if the physician does not feel comfortable with the communication.

Frank communication should be initiated as soon as serious problems are anticipated, especially when prognostication indicates that a patient will become incapable or will face end-of-life issues. It is advisable to speak to the patient and to persons who are likely to be the proxy decision makers if the patient becomes incapable.

Communication about end of life decisions should be honest and thorough. An initial "warning" statement by the physician might be appropriate, such as "I'm afraid I have some bad news." Words such as "death" and "dying" should not be avoided.

The patient needs to understand what is being said, so medical jargon should be avoided. Exact times should not be used to predict when the patient is likely to die. A physician should avoid statements such as "You have three months to live." Exact predictions are difficult to make. But one should indicate, for example, that it is likely that the patient will not live for more than a few months.

In general, patients should not be deceived. Patients should be asked if they understand what is being said. Health care professionals should listen carefully and avoid interrupting.

A suitable private and quiet place should be used. Enough time should be allocated so that the discussion is not rushed. Health care professionals should appreciate that patients and proxies may become emotional during the discussion.

Patients should be informed that a time may come when aggressive or curative treatment would no longer be effective. They should be encouraged to have an advance directive covering relevant circumstances, and should communicate their desires both with the health care team members and with their proxies.

It may be appropriate to talk about palliative care, designed to provide comfort and not to prolong life, and needed personal support at the end of life.

Communication with patients should, where appropriate, indicate that at the emphasis may shift from prolonging life to symptom management in order to enhance quality of life. This would give the patient an opportunity to finalize goals and desires.

If the patient or surrogate decision maker insists on care thought to be inappropriate by the health care term, respectful continuation of communication may be the most effective
approach. Health care professionals should keep in mind that value judgments are involved, and the patient or the surrogate may have a valid point of view.

Communication may be hindered by language barriers. This may require a translator, either at the site or via a phone service.

It may be better to enlist a professional translator than to use a family member. This would allow family members to stay attuned to the concerns of the patient, and it may provide a more accurate translation, given that technical issues that may be involved.

Sometimes physicians are told that patients do not want information. This might be linked to cultural practices. Patient desires should be respected when patients make it clear that they do not want information. If a family member conveys that information, it should be checked with the patient to make sure the patient approves.

We conclude by saying that good communication - the earlier the better - is the best way to avoid conflict over treatment at the end-of-life.