Point of view

Futility and its cost in the management of the critically ill patient

When dealing with a critically ill patient the clinician does not focus on cost *per se* but on making the patient better (even if common wisdom suggests that the clinically 'second rate' is also economically wasteful). There will always be ways that one can improve the patient's care by spending more money. Nevertheless, the fact remains hospital administrators do not have an unrestricted budget and health funding is not limitless despite the professed aim of the World Health Organisation of 'health for all by the year 2000'.

While, in theory, clinicians should administer the highest quality of care at the cheapest price, defining what is the highest quality of care that can be attained at the cheapest price will always be difficult. What often begins as the best medicine at the lowest possible price becomes, sooner or later, an obsession with cost (as it can be easily measured whereas 'best medicine' is not easily measured) and how to provide this at the lowest cost (i.e. what is politically tolerable). The unsavoury facts concerning the cost of acute medical care include, 1) medical costs are rising faster than the cost of living, 2) 50% of a hospital budget is spent on the last 6 weeks of life, and 3) more than 70% - 80% of the hospital budget is used for wages (i.e. to reduce hospital costs doctors and nurses need to be fired).

The sick patient is not an economic person. He or she is ignorant, fearful, helpless, miserable, wanting health at almost any price. They want the doctor to consider their problem with no other thought other than how to best restore his or her health. They want no second best and certainly do not want his or her needs weighed against the claims of other patients. The patient, in brief, is looking for a 'trustee' not a 'provider' and as such wants to be considered as a beneficiary not a consumer. The clinician also wants to be able to discharge this trust as effectively as possible without being influenced by matters of over servicing or over providing.

However, public expectations of the hospital system continually change. In the 1960's to receive long-term mechanical ventilation (i.e.'life support') a patient had to have had a knighthood, a career, a loving family and a friend on the hospital board. Today a heartbeat is sufficient. Interestingly, people who pay nothing towards the cost of their care make substantially heavier demands on health services than those who don't. Total expenditure rises steadily as payment by the user falls.[1] Concerning these expectations and use of the intensive care unit; 'not for cardiopulmonary resuscitation', 'not for invasive ventilation' and withdrawal of therapy are now becoming harder and harder to direct. Despite careful and considered discussion, some remain suspicious and believe that financial triage and not futility determine the use of 'CPR' or 'life support'. The patient's relatives expect unrestricted access to health services and believe that it is 'their right' to have this service, demanding the use of this 'futile' support and perfect results. If these expectations are unfulfilled they are now likely to consult their lawyers, and do so even though there is evidence to show that clinicians are becoming better qualified, better trained and more conscious of malpractice. Intensive care is a growth industry.

One of the freedoms of our society is that we are allowed to make our own judgement in what we wish to be foolish about when it comes to spending our own money. However, when health issues are at stake, it seems that we are able to be foolish about spending other people's money as well. Hospitals provide care for millions of people who cannot pay, the poor may be denied social service of shelter and food yet they are not denied an operation and intensive care services that can cost thousands of dollars.

All this indicates that the intensive care community (i.e. physicians and nurses) must communicate and inform the public of the realities of life threatening diseases, the influence of co-morbidities and the benefit, or otherwise, of prolonged life support. We offer treatment that can cure but in the event of unremitting disease we do not offer miracles.

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REFERENCES

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