Book report

International perspectives on intensive care at the end-of-life: the futility movement seems alive and well

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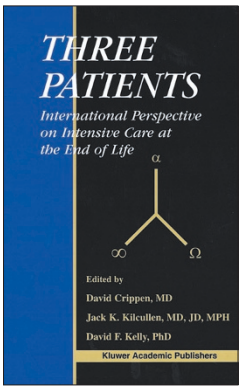

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Crippen D, Kilcullen JK, Kelly DF: *Three Patients: International Perspectives on Intensive Care at the End of Life.* Boston, MA. Kluwer Academic Publishers; 2002. 275 pp. ISBN 0-7923-7671-4 (Hbk)

A recent book entitled 'Three Patients: International Perspective on Intensive Care at the End of Life' [1], edited by Drs Crippen, Kilcullen, and Kelly, provides a fascinating window into the complex issue of use of the principle of medical futility in critical care practice. The editors constructed three cases, designed to range from a patient likely to benefit from the therapy we call 'intensive care' to a patient for whom this therapy would provide no benefit and therefore could be considered medically futile. They then identified critical care physicians from 11 countries around the world to comment on how they would approach treating these patients both under current circumstances in their country and under circumstances of unlimited resources. What follows is a fascinating collection of remarkably different approaches and rationales. Some critical care physicians believed that the first patient, a case that may clearly benefit from critical care, would not benefit and therefore should not be offered this treatment. On the other hand, the patient who, from the editors' perspective, 'cannot be saved by any means and should be denied critical care on the basis of medical futility' evoked from some physicians a recommendation for a trial of intensive care. This variation in approach to critical care at the end of life is not surprising and has been described previously within a single country [2]. Furthermore, considerable international variation in the approach to critical care at the end-of-life has also been described [3]. What this book adds to these important issues is that it demonstrates considerable variability in the rationales toward application of the principle of medical futility, and variation in the way in which resource constraints effect the clinicians' reasoning.

I find this book most interesting in the insight that it provides into the American experience with confronting the principle of medical futility. In 1991, the American Thoracic Society defined a life-sustaining intervention as futile '… if reasoning and experience indicate that the intervention would be highly unlikely to result in a meaningful survival for that patient' [4], and reasoned that such therapy could reasonably be withheld without consent from patients or their families. Several years later, the Society for Critical Care Medicine came to similar conclusions [5]. There have been cogent descriptions of the definition and value of this principle in medical decision-making [6,7] and evidence has been reported that the principle of futility is currently being used in clinical practice in the USA [8]. There have also been cogent arguments made against the use of the futility principle [9–11], and a recent article proclaims the 'fall of the futility movement' based on these arguments [11]. The book edited by Crippen and colleagues provides persuasive, albeit anecdotal, evidence that declaration of the 'death' of the futility movement is certainly premature, if not a misdiagnosis. It provides insight into current clinical practice throughout the world, as well as commentaries on this practice from prominent leaders in the field. In the end, the book is not able to summarize the multiple perspectives on the issue of medical futility in a comprehensive way or to provide a consensus approach to this issue. This limitation is not a shortcoming of the editors or chapter authors, but is rather a reality of our current fractured and contentious approach to the appropriate use of the principle of medical futility in clinical practice. Nonetheless, the book provides useful insights into this complex issue and opens another chapter in

the fascinating history of the debate on medical futility and its use in critical care practice.

Competing interests

None declared.

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