Moral Distress Amongst Physician Trainees Regarding Futile Treatments

Traci N. Adams, MD

Department of Pulmonary and Critical Care Medicine, University of Texas Southwestern Medical Center, Dallas, TX, USA.

J Gen Intern Med 31(8):831

DOI: 10.1007/s11606-016-3647-9

© Society of General Internal Medicine 2016

I was interested to read the qualitative investigation by Dzung et al. of moral distress in physician trainees due to futile treatments at the end of life, which found that trainees experienced moral distress when they felt obligated to provide treatments at or near the end of life that they perceived as futile.¹ Futile care has been defined as “aggressive treatment or interventions such as the use of life support therapy in terminally ill patients who are highly unlikely to survive or have a successful outcome.”² I suggest that residents may be particularly susceptible to mislabeling treatments as futile due to their disproportionate exposure to inpatient medicine and their limited knowledge base, and I propose a long-term outcome curriculum in order to help trainees cultivate an evidence-based approach to identifying and potentially avoiding futile treatments and the resultant moral distress.

Due to the heavy burden of inpatient rotations in internal medicine (IM) residency,³ trainees treat a disproportionate number of patients whose care they perceive as futile, while only infrequently seeing the success stories of outpatients who have done well after critical illness. This exposure to critically ill patients may lead them to overestimate the number of treatments that are futile, simply because they seldom see patients recover from critical illness. A long-term outcome curriculum may help residents to more accurately identify futile treatments by providing them with an evidence base to accompany their clinical experience.

This curriculum should provide an evidence-based approach to treatments commonly offered at or near the end of life. Major topics should include prediction rules for survival rates in sepsis, acute respiratory distress syndrome, congestive heart failure, and stage IV cancer of common primaries such as

the breast, lung, prostate, and colon. By correcting the knowledge deficit with regard to outcomes of serious illnesses, residents may be better prepared to distinguish between futile treatments and those with evidence of benefit. I suggest that this curriculum would ultimately reduce the number of treatments that residents perceive as futile, which could reduce their moral distress when providing these treatments. In addition, equipping residents with outcome data may enable them to have productive discussions with attending physicians when futile treatments are suggested. While evidence-based medicine will not be able to definitively distinguish between futile and non-futile treatments in all cases, it can form the basis of trainees’ assessments of futility.

Corresponding Author: Traci N. Adams, MD; Department of Pulmonary and Critical Care Medicine, University of Texas Southwestern Medical Center, 5323 Harry Hines Blvd, Dallas, TX 75219, USA (e-mail: tnfadams@gmail.com).

Compliance with Ethical Standards:

Contributors: There were no other contributors to this manuscript.

Funders: No funding was used for this manuscript.

Prior presentations: This paper has not been previously presented.

Conflict of Interest: There are no disclosures or conflicts of interest to report.

REFERENCES

1. Dzung E, Colaizzi A, Roland M, et al. Moral distress amongst American physician trainees regarding futile treatments at the end of life: a qualitative study. *J Gen Intern Med*. 2016;31:93–9.
2. Council on Ethical Judicial Affairs—American Medical Association. Medical futility in end-of-life care: report of the Council on Ethical and Judicial Affairs. *JAMA*. 1999;281:937–41.
3. Accreditation Council for Graduate Medical Education. ACGME Program Requirements for Graduate Medical Education in Internal Medicine. Available at: https://www.acgme.org/acgme/Portals/0/PFAssets/2013-PR-FAQ-PIF/140_internal_medicine_07012013.pdf. Accessed January 6, 2016.