

Futility, communicating bad news and burnout in doctors and other health practitioners

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Futile medical interventions have virtually no chance of success. Doctors might perform such procedures because of pressure from families or patients. The doctor might also have an ulterior motive of gain or prefer to do it rather than take time to communicate with the patient about a poor prognosis. Established ways to communicate bad news to patients are not always used by managing physicians with time constraints. The SPIKES protocol method is outlined to assist in sensitive communication where further intervention is futile.

This review primarily explores various aspects of medical futility. It also explores strategies for effectively communicating with patients and their families regarding futility interventions. A side-effect of futile interventions is burnout in doctors and other health practitioners (HPs). The complex relationship between futility and burnout is described.

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Medical futility occurs when an intervention is performed that has little or no chance of success.^[1] Doctors might do this because of family and patient pressure, financial gain or other perceived benefits such as teaching new procedures to train doctors.

Performing futile interventions is not only considered unethical and introduces unjustified risk to patients but also indicates burnout in healthcare workers.^[2,3] Futile interventions may also induce stress and depression in doctors who may withdraw from their colleagues, patients and families.^[2,3] It may seem easier to do something, however pointless, rather than dealing with admitting treatment has failed and taking the time to convince families of futility.

Ethically, the situation requires the balancing of several complex interactions that underlie the decision-making process preceding medical interventions. Essentially doctors are not required to provide futile treatment.^[4]

South African (SA) doctors practice within an often stressful work environment characterised by shortages and understaffing issues in public sector hospitals, as well as financial pressures and fear of malpractice claims in the private sector.

This review primarily addresses and reviews futility in medical care. Secondly, it examines methods for effectively communicating such bad news to patients and their families. Additionally, it seeks to highlight futile interventions as an indicator of burnout in doctors and other health practitioners (HPs).

In many cases, decisions on futility or alternative courses of action are made by doctors in consultation with the patient (and family). This review is tailored to provide insights for them. There are other HPs registered with the Health Professions Council of South Africa (HPCSA),^[5] such as nursing personnel psychologists and others who play a role in patient care decisions.

Medical futility

Medical futility may most simply be viewed as the futility of performing a single health intervention and its advisability. It may also be applied in some instances when continued or different patient treatment is considered pointless because of the limited prognosis for life (or successful outcome).

The concept of futility is 'semantically fuzzy,' so it is simpler to consider one decision rather than overall patient care. A decision not to resuscitate might be taken, not because it is impossible, but because it is subjectively judged that the resulting quality of life would be too poor.^[6]

A futile intervention will have little or no chance of success and is 'virtually certain' to fail.^[1,7] A treatment with no medical benefit might still have value in terms of offering hope or positivity to an otherwise dismal situation (beneficence), but this is of limited value to the patient. An example of this is the continuation of high-level care such as ventilation, to sustain a patient's life, allowing distant family to visit or even attend the inevitable funeral. The needs of other members of society also require consideration to ensure justice and equal access to scarce resources. This must be factored into the decision to continue or discontinue further interventions.^[4]

In deciding whether treatment is futile, a second independent opinion is considered wise to confirm the assessment.^[4] A rigorous review evaluating 19 studies showed how difficult it is to define futility.^[8] In these studies, there was a consensus that the determination of the futility of further intervention relied more on clinical judgment than absolutes. Qualitative elements were thus seen to be important but where possible quantitative aspects may be of assistance. A lack of patient benefit is a common element in futility but is easier to see in retrospect, and much uncertainty exists for clinicians in the decision.

Evaluating the possible success of a management plan is an ongoing part of a clinician's day. However, there are some suggestions to formalise the process, particularly where the chances of success are low. Quantifying the outcome has been described, and when the chance of success is as low as 1%, it signifies a minimal possibility, rendering the intervention futile.^[9] However, in fatal diseases, a patient might grasp even a low success rather than the alternative.

One way of approaching this decision is through the 'surprise question', which prompts clinicians to consider whether they would be surprised if the patient were to die in the next year. This simple question was shown to be an accurate assessment by doctors and senior nurses in heart failure patients, although they tended to over-predict patient deaths in the next year.^[10] This means that the test was proficient at predicting which patients would die (sensitivity of 0.85), but less precise at identifying who would not (specificity of 0.59).

The clinician might ask whether the intervention would still be of value to the patient if they were only to survive a relatively short time. Certain surgeries, such as cataract surgery in a blind patient might be very beneficial even if the patient lives only 3-6 months after the surgery.

Futility is contextual and contingent upon the available skills and facilities. Therefore, a futile situation in Africa might not be futile in first-world medical centres. Futility may also be influenced by attitude and depend on the doctor and patient's willingness and financial ability to persevere. In SA, disparities exist in healthcare, where certain procedures are offered in private practices but may not be an available option in the public sector.

The doctor has traditionally judged the futility of further management or specific interventions, which may sometimes create conflict with patient autonomy. Debates around doctor and patient autonomy have raged for years.^[11]

Ethically, in SA, patient autonomy should in most cases override other ethical pillars of beneficence, non-maleficence and justice. The HPCSA guidelines on terminal care are emphatic on patient rights and their primary role in decision-making.^[5] The same approach is largely appropriate in futile interventions although the patient might lean heavily on the advice of the doctor or healthcare team.

Some patients may request or even demand a further procedure that they can fund, which they believe may benefit them. Some might feel they have little to lose and regard the cost as inconsequential. The issue of justice in the distribution of medical resources argues against the ongoing hopeless attempts doomed to fail. For the care of the terminally ill, the World Medical Association Declaration of 2006 appears in the HPCSA guidelines and states that a '*physician must not employ any means that would provide no benefit to the patient*'.^[5] In SA, the doctor is not considered legally or ethically obliged to perform futile procedures.^[4]

The HPCSA^[5] states that where the patient requests futile treatment, they must be transferred to a centre where the treatment may be given, or failing that as an option, an independent second opinion may be suggested and recommended. The doctor can then refuse to perform the intervention or withdraw the treatment.

At the point of futility communication replaces intervention

It has been suggested that the complex issue of futility might be reduced to three points being present:^[1]

1. *There is a goal.*
2. *There is an action aimed at achieving that goal.*
3. *There is virtual certainty that the action will fail.*

Using this approach in discussing futility with patients and families, the problem has been found to occur in agreeing on achievable treatment goals and the chances of success.^[1] Where patient expectations are unrealistic, this needs exploration and should be addressed so that communication replaces intervention.

Informing patients of 'bad news', including the futility of further intervention, is difficult for doctors seeking to help and cure. Bad news refers to '*any information likely to alter drastically a patient's view of his or her future*'.^[12] When the point of futility is reached, this must be explained with empathy and ongoing support for the patient.

There should be an agreement between the doctor and patient (including family) about the futility of intervention and the doctor should outline a plan for further patient support, such that the patient does not feel abandoned.

Lengthy communication with patients and families may not be feasible for busy clinicians, but efficient ways of achieving this have been suggested. In the mid-80s, an oncology registrar was perplexed by the fact that at a time when conveying bad news was commonplace, oncology doctors found it challenging. He and others have described the barriers that prevent doctors from discussing futility.^[12,13] Bearers of bad news often get blamed, and doctors described this as an important concern. Other barriers included fears of how the patient and family might react to the news and having to deal with their emotions. The doctor might seek to shield the patient from the news and feel inadequately trained in the required communication skills. In a survey of surgeons, 93% agreed that the skill of imparting bad news was very important, but only 43% felt they were adequately trained to do so.^[14] A systematic review showed that Europeans and Americans (including African Americans) generally favour hearing the truth, whereas other ethnic groups such as Hispanics may not want bad news.^[15] It is essential to be sensitive to such cultural preferences.

Various methods of effectively communicating bad news have been proposed, with Buckman being recognised for his contribution to the SPIKES protocol.^[16] Originally designed for cancer patients, this protocol has since been modified by others for use in different specialities.^[13]

In the acronym SPIKES:

S is a quiet setting or appropriate environment and time allocated for discussing futile situations with the patient/family.

P is the patient's perception of where things stand. Often, the patient might have different perceptions of the seriousness of the situation and of what is possible.

I is an invitation to or permission from the patient to pursue a discussion. Not all want to face the situation at that point, and cultural differences might dictate sensitivity in how to proceed correctly.^[15]

K is imparting knowledge - a role that doctors are usually comfortable in. Incorrect patient perceptions can, at this stage, be addressed so that everyone is 'on the same page'.

E is emotions and empathy. This is considered helpful if doctors express both, although some doctors might not be comfortable doing so.

S indicates the strategy that will be followed from this point. It is vital at this concluding point to indicate ongoing support so that patients do not feel a sense of abandonment or hopelessness.

When discussing futility with a patient, begin with a discussion and alignment of goals. It is important to avoid starting with futility, as it may unleash negative reactions. Disagreement on goals and what is achievable is regarded as a major hurdle,^[11] hence starting with goals is easier and kinder.

As the endpoint is to establish an agreed-upon strategy, the initial enquiry into patient perception and knowledge is critical. If the patient perceives further intervention as undesirable or unhelpful, it may shorten the discussion process, although sometimes reaching this point takes several discussions.

When about to deliver the news of futility, it is suggested that a good strategy is to 'fire a warning shot' to indicate your intention and remember that denial is a coping mechanism some may depend on.^[13] Within some care units, it might be helpful to have a healthcare team member who deals with communication with the patient and family other than the treating physician.^[3]

Ways forward in a futile situation

Simple, obvious and essential is getting a second opinion. Hopefully, suggest someone who might be able to offer further effective therapy, but just sharing the 'sense of failure' is therapy for the treating doctor.

Ancillary treatment like pain relief, psychiatrist or psychologist support^[13] or social workers might assist patients in adjusting to a loss. Family and friends' support should be encouraged, along with any other means of hope like prayer or in-person and online support groups. Sensitive nursing care is crucial if the patient receives bad news in a hospital setting.

Futility is an objective assessment and differs from hopelessness, a subjective response related to desire, faith and denial.^[9] The doctor and other HPs can therefore attempt to directly address hopelessness, sadness and grief but not futility.

Burnout in doctors and other HPs

The relationship between perceived futile interventions and burnout is complex.^[2,3] Doctors may feel pressured by patients or families to do pointless interventions but then react by feeling a lack of self-worth and job dissatisfaction and consider a career change.^[3] Continued futile procedures may be a marker for burnout in physicians. The converse, where burned-out doctors might become ineffectual and consider most interventions futile, is unproven but seems possible. While performing futile interventions spares doctors from dealing with the situation, it is fruitless and ethically unsupportable. Where we see colleagues performing futile interventions, we might wish to assist but are unsure how.

Doctors such as oncologists are sometimes the bearers of bad news several times a week. When Balint recognised the need for doctors to meet and talk to each other about their experiences, he set up doctor support groups known today as Balint groups.^[17] From his own experience, he wrote: '*... by far the most frequently used drug in general practice was the doctor himself, i.e., that it was not only the bottle of medicine or the box of pills that mattered, but the way the doctor gave them to the patient—in fact the whole atmosphere in which the drug was given and taken.*'

The doctor needs to be mentally and physically strong and healthy to play this healing role, but resilience sometimes fails. Doctors often feel guilt, shame and doubt when they lose a patient or when they lack the skills to prepare a patient for bad news or the next stage of their illness. Nurses working in intensive care units experience emotional bonding with some patients and suffer moral injury and burnout associated with futile actions they might have to perform.^[18] Burnout might also result from pressures of home and family care, their state of health, mental fortitude and levels of support, so it is not possible to assign simple cause and effect where burnout results.

In SA, doctors, especially those working in the public health sector, deal with a traumatised society as well as load-shedding, water shortages, stock-outs and inadequate equipment. There might also be poor governance and leadership in public sector hospitals, mirroring this challenge at higher levels in SA.^[19] In private practices, the daily struggle with healthcare funding to get paid for services and help patients get their due benefits may be stressful and add to the workload. These factors come on top of considerable challenges in disease management.

The Mayo Clinic^[20] describes job burnout as '*a special type of work-related stress – a state of physical or emotional exhaustion that also involves a sense of reduced accomplishment and loss of personal identity.*' They point out that while burnout is not a medical diagnosis, '*some experts think that other conditions, such as depression, are behind burnout. Researchers point out that individual factors, such as personality traits and family life influence who experience job burnout. Whatever the cause, job burnout can affect your physical and mental health.*'

'Moral distress' occurs in critical care nurses from abnormally stressful situations of illness and death as well as pain and futile endeavours, which may be a part of critical care nursing.^[18] These caregivers may suffer emotional exhaustion, negative and cynical feelings towards patients (depersonalisation) and lack of job satisfaction. Interestingly, religious nurses showed less emotional exhaustion, perhaps because of a different perception of living and dying.^[18]

Doctors involved in end-of-life decisions and futile patient care may show burnout due to stress and moral injury.^[3] In a survey of 349 HPs, avoidance behaviours were detected in doctors. These included avoiding the family who instigated much of the futile treatment, colleagues and the patient themselves.^[3] This survey was conducted online within departments of medicine, surgery, neurology and intensive care across general hospitals in two large urban areas in the northeastern USA. Even witnessing futile care was associated with compensatory avoidant behaviour. Levels of burnout in urban hospitals in sub-Saharan Africa are regarded as at least similar to other areas in the world, although there are fewer reported studies.^[21] A survey of burnout among registrars in training in Johannesburg, SA, revealed a burnout rate of 84%.^[22] This report showed a rate higher than has been reported elsewhere and was attributed to resource constraints and demand overload.

Burnout is regarded as a complicated problem that should be dealt with using a bundled strategy, including individual-focused or organisational interventions, stress management and resilience training, as well as enhanced interpersonal interactions with colleagues through personal training.^[23] Sometimes doctors deal with their stresses through less organised methods, such as a social drink with a colleague, creating an informal setting where they can listen to each other and offer support. In SA, formal support is less commonly

available so this might be the only available therapy. There is also a risk that doctors who are unable to acknowledge their feelings might resort to denial or substance abuse as coping mechanisms.

Ideally, doctors would show resilience. Resilient people are invaluable as they strive to find positive solutions to problems, adapt to changing circumstances and are confident in their ability to make a difference.^[24] They inspire others and might revel in challenges that cause burnout in some doctors.

Resilience can be trained in doctors as it is done in USA military personnel.^[24] This may include providing proper support for junior staff and encouraging their intellectual growth. It might help to facilitate them sharing their experiences, positive or negative, with their peers to grow resilience in each other. Boundary and limit setting must be encouraged to prevent burnout and promote resilience.^[24] The desirability of training resilience in doctors like foot soldiers to care for people has been questioned.^[25] Resilience training is not always successful and might require more leisure time and fewer work hours, and it is difficult to set boundaries where work hours are inflexible or may even increase during periods of training. Demands placed on doctors for more research output and increasing administrative load^[26] serve to erode efforts to develop resilience. Doctors and other HPs should always feel they can seek support from colleagues and institutions, including ethics departments and committees, to avoid or manage burnout.

'Burnout leave' has been suggested to combat an increasing problem of burnout worldwide.^[27] An extensive review of burnout in the workplace recommends that in SA, burnout be recognised as an illness and the work week be restricted to 40 hours.^[28] The Maslach Burnout Inventory (MBI) is a tool used to measure burnout, and the work stressors causing burnout are different in each speciality but are considered exceptionally high in psychiatry.^[29]

There are several challenges that psychologists face when treating physicians.^[30] These include a reluctance on the part of physicians to ask for help, take sick leave and trust other caregivers. Physicians liked to see themselves as selfless and enduring. Obstacles to them being able to make use of counselling were the level of exhaustion when they did seek help, their guilt about reducing their workload and the fact that most of them did not have general practitioners. Physicians viewed their medical training, professional culture and public image as contributing to their reluctance to accept psychological treatment.

Acceptance of help might be better if doctors received Continued Professional Development (CPD) ethics points for hours spent in therapy for burnout, including organised discussion groups like Balint groups.

Addressing causal factors rather than accepting burnout in the medical setting might increase hospital staff retention. Improved systems that streamline patient care and reduce administrative load could assist in preventing burnout.^[26] The obvious role players needing to contribute to these efforts are employers including government hospital services and universities, especially medical schools and examining bodies, which may all increase stress by increasing demands on doctors and other HPs.^[28] Administrative loads have increased in most areas of the world and are felt even more in places where support services are poor, as in SA. Ethics departments and committees may assist clinicians by interpreting the law to resolve conflicts between patients or families and

physicians.^[31] Advising on the correct ethical way forward and facilitating communication can assist in finding solutions to issues of futility and play a role in preventing burnout in doctors.

The harsh reality within the healthcare sector in SA is the growing demand for patient care, particularly in the public sector where patient numbers have increased. If the numbers of HPs remain unchanged, innovations and practical ideas will be needed to manage increasing burnout.

Conclusions

It is vital to recognise and effectively deal with futile patient care as it causes stress in HPs and might indicate burnout. Some supportive action is indicated where colleagues are seen embarking on ongoing futile interventions.

Managing futility best begins with discussing the goals of treatment and what reasonable objectives might be. The discussion would proceed to agreement on principal points and outline a way forward to address abandonment.

Burnout can be prevented or mitigated by adequate support structures, including suitable management structures. Encouraging doctors and other HPs to discuss stressors can assist, along with providing collegial support. It should not result in an inward-directed healthcare team but ultimately in better patient care.

Statistics around the prevalence of burnout in different groups of HPs are needed, and further research in this area including assessment of interventions, would assist in combatting burnout.

The role of employers and universities is pivotal. A barrage of paper and electronic demands top-down is sometimes an all-too-common management style. These demands may exhaust over-stressed clinicians rather than getting efficient and streamlined output. Ethics departments might assist in supporting and advising HPs, resulting in benefits to the healthcare service in SA.

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