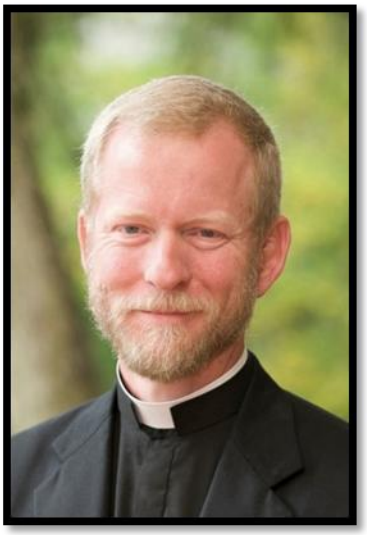

Making Sense Out of Bioethics

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What About Ventilators?
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The use of ventilators can pose particulary challenging problems during end of life situations for families. When should we place a loved one on a ventilator? If somebody is on a ventilator, can we ever "pull the plug?" Understanding our moral duty depends upon whether the use of a ventilator in a particular case can be considered "ordinary" or "extraordinary."

Ordinary interventions can be understood as those medicines, operations and treatments that offer a reasonable hope of benefit for the patient and that can be obtained and used without excessive pain, expense, or other significant burden. Use of a ventilator will sometimes satisfy these criteria, and other times it will not, depending on the specifics of the patient's situation.

Consider a young woman with serious pneumonia who is having difficulty breathing and is placed on a ventilator. The physicians treating her believe the pneumonia eventually can be controlled so that she can be weaned off the ventilator and breathe on her own in a few days or a week. They believe the device will be needed mostly as a temporary "bridge to healing," that it will be effective while in use, and that it will not impose much burden on her. In such circumstances, the use of the ventilator could reasonably be considered "ordinary" and thus morally obligatory.

Whenever there is a considerable hope of recovery from the illness by making use of a particular means (a ventilator, in this case), and when the patient can employ the means without much difficulty or burden, it is likely to be "ordinary" treatment. Thus, in the experienced hands of a well-trained physician, in a developed country with access to proper medication and equipment, intubation and ventilation of a patient can be a low-burden intervention.

The difficulties associated with using a ventilator, however, can become notable depending on the details of a patient's situation. Dr. Stephen Hannan, a pulmonary and critical care specialist in Fort Myers, Florida recently summarized some of the burdens associated with ventilation, noting particularly

> "…the physical discomfort of the endotracheal tube going from the mouth, traversing the oropharynx, crossing the larynx, and reaching the trachea. Sedation, analgesics, and physical restraints are often necessary. The patient cannot talk while ventilator support is in use. The ventilator exposes the patient to greater risks of infection and barotrauma [damage to the lung tissue from the pressure of ventilation]. Even an untrained observer will recognize that the burden imposed by a ventilator with a standard endotracheal tube is much greater than the burden of a feeding tube."

We can consider an example that highlights these burdens: an 85 year old grandfather is placed on a ventilator after suffering several serious strokes that damaged his brainstem so that he cannot breathe on his own. The physicians treating him are convinced that the damage from his most recent stroke will continue to get worse, with the nearly-certain outcome that he will die in a few hours or days. Assuming that he is unconscious, and that other matters have been taken care of (last sacraments, opportunities for loved ones to say goodbye, etc.), the family could reasonably conclude that continued ventilation would be "extraordinary" and decide to have the ventilator disconnected, even though it would mean their grandfather would be expected to die in a matter of minutes without it. Such an act of withdrawing the ventilator would not be an act of euthanasia, because he would be dying due to the underlying condition. It would be a recognition of the burdensomeness of continued ventilation and an acknowledgement that heroics are not required, especially when death is imminent.

Occasionally ventilators may end up being part of a long-term solution for a patient. Christopher Reeve, who played Clark Kent in the movie "Superman," for example, was able to live for several years with a tracheostomy and a ventilator following an equestrian accident that severely damaged his spinal cord. The ventilator, while clearly a burden, offered many benefits to his situation as well, and in the final analysis, seemed to be a reasonable and proportionate intervention for his particular set of circumstances.

Other cases with ventilators can be more difficult to decide, because a prognosis may be uncertain or debated. Sometimes the expense of providing long term ventilation and critical care may need to be factored into the judgment about whether ventilation is ordinary or extraordinary. Determining whether there will be a "reasonable hope of benefit" to a particular patient by using a ventilator can be challenging. Each case must be considered on its own merits, as we seek to make a good prudential judgment, and to provide for our loved ones in a way that corresponds to their real medical needs, so that we neither neglect nor overburden them in the face of powerful medical technology.

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