

Ethical Concerns that Arise from Terminal Weaning Procedures of a Ventilator Dependent Patient a Respiratory Therapists Perspective

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Citation

S Keene, D Samples, D Masini, R Byington. *Ethical Concerns that Arise from Terminal Weaning Procedures of a Ventilator Dependent Patient a Respiratory Therapists Perspective*. The Internet Journal of Law, Healthcare and Ethics. 2006 Volume 4 Number 2.

Abstract

The purpose of this article is to take a closer at look at ethical concerns that respiratory therapists face while performing terminal weaning procedures on ventilator patients. The article explains the process of removing assistive ventilation and why terminal weaning is preferred over terminal extubation. It explains why patients with brain death are easier to terminal wean from an ethical perspective. The paper provides a critical analysis of the ethical issues using the four method approach to health care ethics which includes: beneficence and nonmaleficence, patient preference, quality of life, and contextual features. The biggest obstacle therapists struggle with overcoming is moral and religious concerns regarding removal of life support. The findings showed that although terminal weaning is a highly stressful job requirement for respiratory therapists, there are protocols and procedures that the employing health care facility can offer to help alleviate some of the associated stress and improve on the situation.

INTRODUCTION

Patients receiving end of life care often require assistive treatment in the form of mechanical ventilation. This process uses a machine known as a ventilator to provide all or at least a portion of a patients total ventilatory and oxygenation demands. Ventilators are often used in short-term applications such as surgery, drug overdose, injury, or acute illness. In these situations the utilization of a ventilator provides a vital role to assist a patient until they are able to maintain their own ventilation once again. However, many patients require mechanical ventilation to survive long-term. These patients are often terminal or their recovery has reached a permanent plateau and they require assisted ventilation to maintain life and would die otherwise.

Respiratory therapists are highly skilled allied health care practitioners that work in all facets of health care. They are trained to specifically manage diseases of the pulmonary system and the airway. One of their highest skill sets involves the care of patients committed to mechanical ventilation and the maintenance and operation of the ventilator itself. This job requires hands on patient care and as with many other health care positions deals with life and death on a daily basis. There is one uniquely different aspect

of this position as compared to most other allied health positions. Respiratory therapists are frequently called upon to remove assistive ventilation to patients which ultimately results in their death.

This process has come to be called terminal weaning by the medical community. Patients that are to be terminally weaned are unable to maintain their own ventilation due to illness or injury and have no expectation of ever being able to live independent of the ventilator. It has been decided by the patient, health care proxy, advance directives, or in some cases the medical support team to terminate ventilatory support for the patient. This process actually requires the respiratory therapist to remove a patient from a ventilator and apply some other assistive device that only provides oxygen in its place. The therapist knows upon completion of this task death will come for the patient anywhere between a matter of minutes or over the course of a couple of days. This can lead to a huge ethical dilemma for many therapists as ultimately even though he or she is doing their job and breaking no laws they are effectively playing a role in ending the life of another individual.

LITERATURE REVIEW

TERMINAL WEAN

The removal of ongoing ventilatory support is a necessary evil when these devices are hindrances to ending life rather than sustaining a manageable quality of life for a patient. The two common methods of removing assistive ventilation are terminal weaning where the endotracheal tube is left in place as assistive ventilation is withdrawn and the other method is terminal extubation where the endotracheal tube is removed while ventilatory support is removed simultaneously. Terminal weaning is the more appropriate of the two methods in most situations unless the patient has experienced brain death. Using this method the endotracheal tube remains in place providing a patent airway and preventing complete airway collapse. Another advantage of leaving the tube in place is so that patients do not experience added stress due to stridor or secretions. This method is especially favorable if family members will be remaining at the bedside of the patient because the potential for airway collapse with a terminal extubation is very real and watching a family member essentially choke to death rapidly is highly undesirable under any circumstances. A consideration to not be overlooked is that even though the procedure is labeled "terminal wean" there is a possibility no matter how remote that the patient will survive and remain dependent from the ventilator. It is important to remember that terminal weaning is not a form of euthanasia. There is no assistance with death in this procedure it merely allows death to occur and not be delayed if ventilatory assisting machinery were not in place (Crippen, 2002).

BRAIN DEATH

Patients that have been deemed brain dead are often much easier to terminal wean for therapists from an ethical view point than other patients. This is true in most cases because patients that are declared brain dead are dead legally. Most religious organizations around the world recognize brain death as true death as well. Essentially in this situation the therapist is not removing life support because the patient with brain death is already considered dead. The classification of brain death requires careful diagnosis by a physician. This can usually be accomplished through a combination of tests such as a neurological exam, electroencephalogram, and brain scans. The therapist and any family members observing the terminal wean should be warned that some patients do jerk, which may appear as discomfort, but are actually only spinal neurons responding

to the state of low blood oxygen or hypoxemia. The tradeoff for the therapist terminally weaning a brain dead patient is that they are often the best candidates for organ harvesting. This means that even though the therapist may bear less guilt because the patient is brain dead he or she will often have to maintain the ventilator in the room until the donated organs are procured from the patient and then terminate ventilation. This can be very traumatizing on the therapist to witness (Wijdicks, 2001).

CONSCIOUS PATIENT

Withdrawing ventilation from a conscious apneic patient is especially difficult for a respiratory therapist. Patients that interact with their therapist no matter on what level that interaction occurs emulate the human experience. They often show cognition by mouthing or writing words and making requests. There is a bond of trust that develops between the therapist and the patient especially if the patient has a long-term commitment to the ventilator. It becomes an expectation of the therapist to see the patient when they come to work.

Conscious patients that have terminal weaning performed quite often participate in the decision in real time or have done so prior through advanced directives. Meetings are held with involved family members, medical staff, and the patient if they are able to participate. The procedure is explained in detail and there is opportunity for discussion and questions. Once all affairs are put in order a date for the terminal wean will be set. The patient will be given a titrated analgesic to aid with discomfort. The weaning will begin in many instances with the patient alert throughout the process until death occurs. This can be a taxing experience for the attending respiratory therapist as the situation may involve going from interacting with a patient to removing assistive ventilation in a very short time span (Campbell, Bizek, & Stewart, 1998) .

FAMILY CONFLICT

Another huge source of distress for respiratory therapists and other clinicians alike is confliction with the family about the decision to withdraw life support on patients. Unfortunately, respiratory therapists can be viewed as merchants of death by family members. Conflict about end of life issues is common place in health care. Family members because of their close attachment to the patient often have a difficult time remaining objective about a prognosis. It is important to remember that the patient, family members, and the

clinicians may all be going through the different stages of the grieving process which are: denial, anger, bargaining, depression, and acceptance. The clinicians will most likely make it to the acceptance phase much quicker than the other individuals involved because of their constant occupational exposure to death.

Research has showed that the best way to solve conflicts with family members is to try to understand first and foremost. They are going through a difficult time and emotions will run high. The most common approach is to educate and negotiate with family members about conflicts that may arise around decision making. Families often disagree about treatment plans because they are simply misinformed or do not fully understand. When a patient's prognosis and treatment plan have been properly explained this may resolve many disputes on delivery of care. Quite often if the patient is capable they are the best resource to defend the terminal wean to the family member. This removes the accusing finger being pointed at the therapist because at that point it becomes patient preference. In addition, clinicians often have to realize that futile care has to be explained to families before they can realize that some therapies must be abandoned or never started for the good of the patient (Way, Back, & Curtis, 2002).

SUPPORT SYSTEM

In order to handle a terminal wean respiratory therapists need the full support of the hospital to properly handle the whole process from a professional, emotional, and psychological stand point. New graduates or unseasoned therapists should not be expected to handle a terminal wean on their own. This would be too much stress for someone just entering the field to be expected to handle without the support of a veteran therapist to answer questions and provide advisement. After every terminal weaning there should be a debriefing meeting for the entire clinical team involved. This provides an opportunity for the therapist to discuss their feelings with other members of their peer group that can relate to the experience. It also provides an opportunity to discuss any opportunities for improvement in future weans. All clinical members should have access to counseling services provided in house by the hospital. Finally, the same therapist should not have to perform back to back terminal weans it should be rotated among the staff to insure this does not happen (Truog et al., 2001).

CRITICAL ANALYSIS

BENEFACTENCE AND NONMALEFACTENCE

All clinicians enter the field of medicine with the hopes of easing suffering and helping patients to get well. Respiratory therapists are no exception they are trained to treat diseases of the pulmonary system and ease difficulty of breathing for their patients. Patients look forward to seeing their therapists on many occasions because the therapeutic modalities they provide ease suffering especially dyspnea. Terminal weaning goes against everything that the field of respiratory therapy teaches to provide for the patient's ventilatory and oxygenation needs at all costs. The principle of nonmalefactence or to do harm is violated by the therapist when he or she removes life supporting ventilation, which results in death. The principle of benefactence is violated in a terminal wean by the therapist because they are preventing the patient from experiencing harm. This creates a huge ethical dilemma for a respiratory therapist. There job duty directly leads to the harm and death of a patient. Many therapists struggle with this and indeed they should. It is very hard to switch modes for a therapist from going all out providing every means of life support to a patient during a code who if they survive will most likely require mechanical ventilation to terminating assistive support on another patient requiring ventilation. Therapists often try to compensate by trying even harder to save the patients that they can. It is almost like playing for a losing team, but getting that occasional win to boost your morale and reaffirm why you play the game (Jonsen, Siegler, & Winslade, 2002).

PATIENT PREFERENCE

The principle of respect for patient autonomy is a hard concept for clinicians to accept when dealing with end of life care management. It is very hard for some respiratory therapists to accept that a great number of patients choose death over a commitment to mechanical ventilation and therefore they are called upon to perform a terminal weaning procedure. This is an example where patient autonomy comes in direct conflict with the therapist's obligatory duty of benefactence and nonmalefactence. Respiratory therapists are trained to safeguard and protect life so every terminal wean creates an ethical dilemma. It truly can become a struggle to obey a patient's wishes at times. These choices become even more difficult when the patient is conscious and actively participating in the decision to withdraw life support. Therapists are hard pressed to accept that patients

have the right to choose the manner in which they live or ultimately die. It is extremely difficult in many instances for a therapist to suppress their heroic instincts and respect a patient's wishes (Jonsen, Siegler, & Winslade, 2002).

QUALITY OF LIFE

The perceived quality of life for each individual is subjective and unique to that individual. One person may find that living with paralysis on a ventilator and having to rely on caregivers acceptable and may go on to lead a fulfilling life; however, another person facing the same situation might find this quality of life unacceptable and decide that continued life is undesirable. Patients often come to the realization once their treatment plan and prognosis has been explained that their perceived quality of life is not worthy of continuing and elect to refuse to continue life sustaining measures. A great deal of these life prolonging procedures that patients decide to terminate involve mechanical ventilation. Respiratory therapist can only make the determination if they were in the patient's situation would they choose to be terminally weaned. Once again quality of life is highly subjective and individualized so it is likely that different people in a given situation will come to different conclusions for different reasons. Therapists often see an ethical dilemma if the patient chooses to be terminally weaned for condition that the therapist themselves feels as though could still yield a good quality of life (Jonsen et al., 2002).

The respiratory therapist may perceive the terminal wean in some instances as an act of mercy. There are extreme cases where patient suffering is so extreme that it overrides the duty of beneficence and nonmaleficence. These cases are rare and not the norm for how most therapists view the terminal wean. Therapists that seem detached or without opinion either way may have seen too much and may actually be suffering from post traumatic stress disorder (Jonsen et al., 2002).

CONTEXTUAL FEATURES

Respiratory therapists often find themselves in conflict with their personal religious beliefs during a terminal wean. Although the therapist is not euthanizing a patient, they are removing equipment that will most likely lead to death. This is a source of internal conflict that many therapists find themselves struggling to rationalize. Some therapists feel that in order to fully satisfy their job functions that they are forced to betray their religious beliefs.

Therapists do realize as well that health care is not always based upon distributive justice. Sometimes terminal weans are pressed when patients do not have insurance or there is a shortage of resources such as a limited number of ventilators. Patients have been terminally weaned to free up ventilators in hospitals for patients in emergency rooms. These decisions were based upon needing a ventilator to save a life not merely prolong it. Participating in a terminal wean knowing this information definitely adds stress to the therapist and brings up ethical questions about the facility and the health care system in general.

Most therapists realize that terminal weaning is not a violation of any law. It is not an act of euthanasia or assistive suicide in any manner. Terminal weaning allows death to take its natural course without mechanical intervention. These realizations still often do little to comfort therapists because most of them feel the laws they have broken are those of morality or religion and not the laws of man (Jonsen et al., 2002).

CONCLUSION

Terminal weaning is one of the greatest ethical dilemmas that respiratory therapists face in their profession. Terminal weaning is almost universally preferred in the medical community over terminal extubation when removing mechanical ventilation in anticipation of death. Respiratory therapists have an easier time terminally weaning brain dead patients because they are considered legally dead already. Patient autonomy often comes in direct conflict with a therapist's duty of beneficence and nonmaleficence which is essentially to do no harm or cause death. Therapists often fail to see the patient's perception of quality of life because it is subjective in nature. The biggest obstacle therapists struggle with overcoming is moral and religious concerns regarding removal of life support.

Although terminal weaning is a difficult part of the job duties of a respiratory therapist, the process can be less stressful when a strong support system is in place at the work place. Staffing schedules can be rotated so that the same therapist does not have to perform terminal weaning all the time. Debriefing periods should be scheduled after every terminal weaning to allow the therapists to voice any concerns or make suggestions within their peer group. Counseling sessions for clinical personnel should be made available in house for those who may need the service.

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