Follow-up: should the elderly woman have been put on a ventilator against her wishes?

We would like to provide follow up and comment on the case study regarding putting a patient on the ventilator against her wishes (1).The dilemma that the daughter and son-in-law, both physicians, had faced was the decision to place this patient on a ventilator despite her repeatedly expressed abhorrence for such a treatment. They asked her at the time that she was gravely ill, hypoxic but seemingly in possession of her faculties if she still held the same views or if she now felt that she would agree to a ventilator if the hospital doctors advised it. She changed her mind and said that she would be willing to abide by the decision of the hospital doctors, including a ventilator if needed. Accordingly she was taken to a tertiary care hospital where she was admitted to ICU, placed on a ventilator for three days and weaned successfully to make a complete recovery. She returned to her activities of daily living in a short time. Surprisingly, she later told her relatives that she had no recollection of the conversation where she changed her earlier decision of refusing ventilator under any circumstances and again exhorted them never to put her on the ventilator again.

The ethicists would say that the relatives did the right thing in asking her again if she wanted to change her earlier decision. The patient in full possession of his faculties has the right to change his mind even after a "Living Will" declining ventilator etc has been made and submitted to the doctor and the hospital. However, an ethically correct decision does not guarantee a good outcome. In her case, the ethically correct decision turned out to be the correct medical decision also but that may not happen in every instance. She could have died a lingering and painful death after being on the ventilator for several days. Would we then have felt as confident of the ethics of asking her if she had changed her mind? Would we have wondered if we made a mistake in asking such a question of a person who was hypoxic and encephalopathic and perhaps not able to make decisions? As it turned out later she must have been encephalopathic as she had no recollection of making the decision to go to the hospital and on a ventilator and has only vague memories of the first day in the hospital. Surely, the bad outcome would have made us doubt the wisdom and ethics of asking such a question of a person who may not have been medically fit to answer.

What one learns from this case is that there are grey areas in ethical decision making as there are in medical decision making and as often happens, it is the outcome of a situation that allows us to either pat ourselves on the back or kick ourselves in the rear. As physicians we would like to spot clues that will help us make the right decision, both ethically and medically, before the outcome becomes known. For only then can we offer sound advice and make medicine more a science than mere inspired guesswork.

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Trust her inner voice

The ethical dilemma herein is resolvable on the basis of two non sequiturs : The avoidance of a ventilator does not always spell death. Insisting on it is no guarantee of survival. It is incidental that Mrs. SBG managed to recover - because of the ventilator, or, may be, DESPITE IT.

It is ethical to pay heed to a sprightly 80 years old, to trust her inner voice, and even to concede that she be allowed to embrace death of dignity at home, in case of an exit while struggling against a ventilator, in an alien setting, much against what the patient had patently expressed, merely endorses Bigelow's comment of mid 19th century- " Most men form an exaggerated opinion of the powers of medicine".The 1986 Oxford companion to medicine, writing about the role of doctors, echoes Bigelow-" It needs to be more generally recognised that most of medicine is about relief of, and comfort in suffering and in main very little to do with saving life."

An editorial in the *New England Journal of Medicine* (305: 1467-269,1981)entitled "The toss-up" bears eloquent testimony to the rationale of the above. It is common experience that, on a given case, the proposed diagnostic or therapeutic thrust ranges from extreme conservatism to surgical ultra- radicalism. After attributing such divergence in medical thinking to the idiosyncrasies of the physicians, the authors propose: 'perhaps all these factors are involved in clinical controversies, but we propose that one explanation has not been sufficiently recognised: that it simply makes no difference which choice is made. We suggest that some dramatic controversies represent" toss-ups" - clinical situations in which the consequences of divergent choices are, on the averages, virtually identical. 'the identicality of the consequences, no matter what the investigations and what the therapy, is a result of the basic fact that the problem being tackled is beyond the limits of technology.

Bottomline: We would have honoured the dictates of Mrs. SBG, avoided the ventilator without being unethical.

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A competent patient can decide

In the case of the 80-year-old lady with COPD, if clinical examination suggested that the lady was alert and capable of deciding about whether she would consent to use of mechanical ventilation, I would go by her decision, and discuss this with the daughter and son-in-law. However, a less traumatic mode of therapy called "non-invasive ventilation" is now available, which does not entail inserting a tube into the patient's trachea. Most patients who have received mechanical ventilation are really distressed by the presence of the tracheal tube and the inability to talk, cough or consume food / water while the tube is in place. Some of these are avoided by non-invasive ventilation. However, this can substitute for conventional mechanical ventilation in only a few, very limited conditions. Fortunately, the