



CLINICAL ETHICS CASE STUDIES

BIOETHICS FORUM ESSAY

Involuntary Withdrawal: A Bridge Too Far?

by [Joanna Smolenski](#)



Published August 21, 2023

Posted in Clinical Ethics Case Studies, Hastings Bioethics Forum

RD, a 32-year-old male, was admitted to the hospital with hypoxic COVID pneumonia—a potentially life-threatening condition characterized by dangerously low levels of oxygen in the body—during one of the pandemic’s surges. While RD’s age gave the clinical team hope for his prognosis, his ability to recover was complicated by his being unvaccinated and having multiple comorbidities, including diabetes and obesity. His condition worsened to the point that he required extracorporeal membrane

oxygenation (ECMO), a machine that maintains the functioning of a person's heart and lungs.

Given its scarcity—only 264 of the over 6,000 hospitals in the United States offer ECMO, according to the Extracorporeal Life Support Organization—as well as its high cost and the inadequate supply of staff required to maintain it, ECMO primarily serves as a bridge to support critically ill patients until they can receive an organ transplant or implanted medical device. For RD, ECMO was started to support him until he could be evaluated for, and possibly receive, a bilateral lung transplant. Despite its intended use as a treatment of last resort, some patients can remain on ECMO for weeks or months. And some are awake, alert, and capable of medical decision-making.

RD was one such patient. However, the transplant evaluation committee ruled out RD's candidacy for bilateral lung transplantation, based on his poor potential for recovery and a lack of family and friends to provide post-transplant support. This determination raised the prospect of continued ECMO treatment being a bridge to nowhere. But RD was comfortable on ECMO and wanted to remain in the ICU. The ICU intensivist contacted the ethics consult service with questions about whether continued ECMO support was medically and ethically inappropriate.

Ethical Analysis and Process

First, the ethics consultants met with members of the ICU team to explore their ethical concerns. The ICU clinicians believed RD's almost certain permanent ICU-dependence rendered continued life-sustaining treatment futile. They also raised distributive justice concerns about using ECMO for a patient who would likely never recover. ECMO-eligible patients from other hospitals were routinely refused admission at RD's facility because of machine and staffing shortages, and approximately 90% of such patients would die as a result. The physicians worried about the fairness of allowing RD to use one of the hospital's few ECMO machines indefinitely when other lives could be saved.

The clinical ethicists then met with RD, who said that he was not ready to die and, in fact, thought he had a good quality of life in the hospital. Indeed, he was alarmed by the possibility that the doctors could disconnect his life support without his consent. RD's perceived right to exercise autonomy over his treatment—as well as to determine what counted as an acceptable quality of life

for him—was in tension with the clinical team’s concerns about providing care they considered to be medically inappropriate and exercising poor stewardship of resources.

The ethics consultants saw multiple issues contributing to the ICU team’s discomfort with RD’s desired care plan. While the physicians felt they could keep RD alive on ECMO, they did not think doing so indefinitely was consistent with their role as healers. In addition, the physicians were concerned that it would be unjust to use scarce resources to maintain a patient in poor health when those resources could be used to cure other patients.

Disambiguating these concerns with the ICU team was crucial to the ethics process. While questions of resource allocation were clearly in the background in considering RD’s treatment, hospitals don’t allow very ill patients to die simply so that their beds can be used by other people. So, it became particularly important to understand RD’s goals of care in the context of the goals of medicine more broadly. Was what RD desired—namely, remaining in the ICU on ECMO for weeks or even months until his inevitable death—a goal that a health care system should not only respect, but effectuate?

With this in mind, the ethics consultants advised continuing discussions with RD about his goals of care (including palliative care and social work services) to ensure that he truly understood that his condition was incurable and that his desire to remain connected to ECMO was the result of his belief that this was an acceptable quality of life for him. Focusing on the reasons for his decision confirmed the authenticity of RD’s preference: he maintained that he wanted to continue treatment. RD and the clinicians ended up at an impasse, with an intractable disagreement regarding what constituted an appropriate plan of care.

Given the unresolved conflict, the ethics team advised bringing RD’s case to the hospital’s ethics committee, an interdisciplinary group that included ethicists, physicians, and community members whose endorsement was required by hospital policy for any unilateral withholding or withdrawing of life-sustaining treatment.

The Decision

The committee's task was to determine whether RD's clinicians in the ICU had established that continued treatment was medically inappropriate under the hospital's policy. If the committee endorsed the clinicians' perspective, the ICU team would have been permitted to withdraw ECMO over RD's objection. However, the committee declined to endorse the clinicians' determination of medical inappropriateness largely because RD had capacity, and so his treatment preferences were respected.

A few weeks after the decision, RD passed away when a clot formed in his ECMO circuit. So, while he was not taken off ECMO against his wishes, his case generated widespread institutional examination of the relevance of a patient's decision-making capacity to clinicians' determinations of medical inappropriateness and unilateral treatment withdrawal under conditions of scarcity.

Lingering Questions

While some practitioners found continuing ECMO in RD's case *medically* inappropriate, ethical concerns lingered regarding the *moral* appropriateness of withdrawal of treatment for patients like RD with decision-making capacity who want to continue aggressive care. And so, the question remains: what ought to be done with treatment long-term for such patients? It is close to canonical in contemporary medical ethics that capable patients should be allowed to establish their own goals of care and, furthermore, to determine what constitutes an acceptable quality of life for themselves. Were these specifications sufficient to justify maintaining RD on ECMO indefinitely? Or is there space for clinicians to say that the only quality of life they will be able to achieve for a given patient is inconsistent with the appropriate practice of medicine, and so they should be permitted to refuse to provide interventions aimed toward that health state?

Joanna Smolenski, PhD, is an assistant professor at Baylor College of Medicine's Center for Medical Ethics and Health Policy and a clinical ethicist at Houston Methodist Hospital. Previously, she was a clinical ethics fellow at UCLA Health.

Series Editors' Comment: Where Public Health Ethics Meets Clinical Ethics

RD's case exemplifies the complexities of scarce, advanced, life-sustaining technologies and the difficulties that arise if we try to distribute them justly. ECMO is meant to be a bridge to transplantation or recovery from critical illness, but sometimes it sustains life without hope of recovery to a life outside of the hospital. In this way, RD's case draws attention to the border between public health ethics and clinical ethics, and the challenges in patient care that arise where they meet.

The primary issue this case raises extends beyond the ethics committee's decision to support RD's preference to remain on ECMO, and importantly so. It is both reasonable and important to approach RD's case individually, as a case to be resolved using the methods of clinical ethics. A decision to not withdraw ECMO is justifiable, not merely because of the obligation to respect the patient's choice, but because it is difficult to argue that ECMO was medically nonbeneficial or inappropriate when it continued to provide both longevity and quality of life.

If an ethics committee instead adopts a public health framing for RD's case, it risks allowing implicit, interpersonal bias to guide decision makers in the moment, since RD is only one person, not a population of persons who are each under consideration for the same scarce resource. Unless an ethics committee can rely on a predetermined process for implementing the norms of public health ethics into the routine ways that health care professionals develop treatment plans with individual patients that can be fairly and equitably applied, the committee is right to focus on how to best respect a specific patient's goals of care. In RD's case, this yielded a treatment plan appropriately focused on respectfulness, nonmaleficence, and beneficence.

However, the responsibilities of health care extend from individual patients to whole communities. There is an undeniable reality in this case that other patients who *could recover* with the support of this resource simply do not have access to it. While it is important for ethics consultants to be cautious when arguments of resource scarcity are employed to justify withholding or withdrawing life-sustaining medical interventions, this is a situation where the resource truly is not available because maintaining RD's life on ECMO entails denying life-sustaining technology to other patients who may die without it. This is a failure of communitarianism and justice, even though it is respectful and compassionate to RD. Ethics consultation services and committees are obligated to address these

broader distributive injustices, but their resolution may be more appropriate to policymaking, rather than patient care.

One of the fundamental challenges to fulfilling the responsibilities of distributive justice is that when the distress of a single case fades, so does the drive to create robust policy and procedures that could synthesize public health ethics and clinical ethics to help allocate resources more fairly to the broader community. This leads to a vicious circle, with each new distressing narrative experienced anew by patients and families and residually amplified for health care professionals, and no end to the impasses encountered with each trip around the circle.

- *Georgina Campelia and Thomas Cunningham*

Learn more about the series, [Clinical Ethics Case Studies for Hastings Bioethics Forum](#).

Read the previous essays in the series [here](#) and [here](#).

Attention clinical ethicists: learn how to contribute to the series.



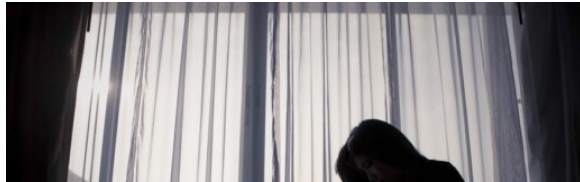
Tagged [ECMO](#), [End-Of-Life Decision-Making](#), [Life-Sustaining Treatment](#)

[Read More Like This](#) ▾

4 Comments on
"Involuntary Withdrawal: A Bridge Too Far?"
[Join the conversation.](#)

RECENT CONTENT

BIOETHICS FORUM ESSAY



Does Calling Severe Anorexia a Terminal Condition Matter?

BIOETHICS FORUM ESSAY



Conscientious Objection and Abortion: Medical Students' Perspective

BIOETHICS FORUM ESSAY



Should Your Wedding Plans Include Plasma Donation?

BIOETHICS FORUM ESSAY



Don't Give Symptom-Free People Alzheimer's Drugs

BIOETHICS FORUM ESSAY

BIOETHICS FORUM ESSAY



Newly Released Documents from Untreated Syphilis Study: Ethical, Just, and Respectful Use of Archival Materials

BIOETHICS FORUM ESSAY



The Genetics of Obesity: A New Narrative or the Same Old Story?

BIOETHICS FORUM ESSAY



Race, Research, and Bioethics: The Chapatis Studies

BIOETHICS FORUM ESSAY



Chemical Weapons Convention Reaches Milestone

BIOETHICS FORUM ESSAY



My Mom's Myeloma and the Fire-Breathing Chimaera

BIOETHICS FORUM ESSAY



Improving Linguistic Justice and Accessibility in Bioethics Work

BIOETHICS FORUM ESSAY



Our System for Reporting Child Abuse is Unethical



Myopic View of Xenotransplantation

The opinions expressed here are those of the authors, not The Hastings Center.

WHO WE ARE

Mission Team What Is Bioethics? Financials
For the Media Diversity, Equity, & Inclusion

WHAT WE DO

Research *Hastings Center Report* Events
Focus Areas *Ethics & Human Research* Webinars
Bioethics Careers & Education

Hastings Bioethics Forum

FAQs on Human Genomics Bioethics Briefings

Books by Hastings Scholars Special Reports



Search

Registered 501(c)(3).

EIN: 13-2662222

SUPPORT US

[Ways To Give](#) [Why We Give](#) [Gift Planning](#)

[Sign up for Updates](#) [Contact Us](#)