Center For Practical BIOETHICS

The Ethics Dispatch

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"Functioning as our better selves leads to better outcomes for patients and everyone."
-- Tarris (Terry) Rosell, PhD, DMin, HEC-C

Hot Topic

No Tidy Answers:

When the ECMO Bridge Leads Nowhere

By Cassie Shaffer Johnson, MA, Program Coordinator

Every now and then, an article for the Hot Topic deeply affects me. Daniela Lamas's opinion piece in *The New York Times* about a young woman, Francia Bolivar Henry, is one of those. It's a moving tribute, but ultimately an unsettling one – a story that sits right at the intersection of modern medicine, human hope, and the limits of what we can or should ethically offer.

Ms. Henry was only in her 30s. A pastry chef. A daughter. A partner. Someone who kept walking the ICU halls even while tethered to machines, determined not to lose her place on the lung-transplant list. And eventually, someone who ended up on ECMO – the last, most intense form of life support we have for people whose lungs can no longer sustain them.

Pushing the Rock of Hope

According to the American Lung Association, "ECMO is a form of life support if you have serious lung or heart failure, injuries, or the heart or lungs are too weak to work properly. Extracorporeal means 'outside of the body.' A membrane oxygenator puts oxygen in the blood and removes carbon dioxide. ECMO is most often used when other treatment options do not improve the lung or heart condition but there is still a possibility of recovery."

However, what struck me was not just the medical complexity of ECMO (which, admittedly, I knew little about before researching this article), but the emotional gravity that came with it. ECMO is described as a bridge – a bridge to transplant, or a bridge to recovery. But sometimes, as Dr. Lamas notes, the bridge becomes "a bridge to nowhere." (Lamas 2022). And that's where Ms. Henry eventually found herself: awake, alert, newly engaged, and surrounded by people who loved her but with no path forward.

There is an ethical heaviness to that reality that I can't shake. Because while ECMO gave her time – time to walk, to smile, to feel the sun on her face, to celebrate her 34th birthday – it also carried her toward a point from which there was no return. The constant state of hope deferred – one moment buoyed by the possibility that a matching donor might appear at any moment, the next brought crashing down by a harsh reality. Over. And over. Again. Life becomes a Sisyphean task, pushing the rock of hope uphill only to watch it roll back, every single time.

Confronting Nonmaleficence

In healthcare ethics, we often turn to the familiar principles when we are trying to orient ourselves: autonomy, beneficence, nonmaleficence, and justice. New to the field when I began at the Center in 2024, I relied heavily on these principles to help me understand ethical issues. For this story, I've thought a lot about nonmaleficence – the obligation to do no harm. But harm is complicated here. ECMO forces us to confront the classic calculation at the heart of nonmaleficence: weighing risks against benefits in real time, with incomplete information, while the stakes could not be higher.

The intention is to minimize harm, yet each option carries its own form of harm, its own uncertainties, and its own costs. Without ECMO, Ms. Henry would have died months earlier. With ECMO, she was given precious time, including time to have a wedding, veil draped over the tubes keeping her alive. As her fiancé put it, the wedding was "perfect and so messed up at the same time." (Lamas 2022). Without ECMO, that wedding never would have happened. With ECMO, she eventually had to face the knowledge that the machine keeping her alive could no longer carry her toward the future she hoped for.

I do not have a clear answer for what "doing no harm" looks like in that situation. I don't think anyone does. And I think it's important to say that out loud. The moral distress of clinicians, the suffering of families, and the profound vulnerability of patients like Ms. Henry collide in ways that our principles can guide but not resolve. This case forces us to confront something that lives beneath the surface of much of modern medicine: our ability to extend life beyond what we ever imagined – and our inability to always make that life meaningfully better.

Accompanying the Journey

There are philosophers who have argued that life itself is a kind of bridge to nowhere – that every life ultimately ends, no matter how hard we try to stretch it. I'm certainly no philosopher (unlike Dr. Pferdehirt), but I understand the sentiment. And maybe this is not about destination (or lack thereof) but the journey. To put it more clearly, even when we cannot alter the destination, we can profoundly shape the experience of getting there. Ms. Henry's team did exactly that. They gave her time. They honored her wishes. They helped her find moments of joy. They allowed her to celebrate her wedding – something beautiful and human and meaningful, even in such impossible circumstances.

So where does this leave us? For me, it's a reminder that healthcare ethics is not a set of tidy answers. It's a framework we draw on while standing beside people in situations where no option feels clean and every option carries some form of harm. It's also a reminder that sometimes our job isn't to find *the* right answer, but to accompany people with honesty, compassion, and courage when there is no right answer to be found.

As the article makes clear, these cases happen quietly, behind closed doors, and they will only become more common as technology advances. But Ms. Henry's story calls us to something larger: to keep asking the questions, to keep examining our responsibilities, and to keep centering the humanity of those who trust us with their lives, even when the path ahead is unbearably complicated or leads to nowhere. We may not always be able to choose the destination, but we can choose how we walk with people on the way.

Sources

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What is ECMO? | American Lung Association

A lifesaving medical technology puts some patients on a "bridge to nowhere"

Bioethics in the News

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nature

Journal of Medical Ethics

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Case Study: Starting ECMO

Husband Requests Intervention for Wife Without Her Consent

Ms. Claudio is a 62-year-old female admitted after suffering a cardiac arrest. She has a long history of cardiac and respiratory complications and has been cared for by her husband, Frank. Since her admission, she has not been able to remain conscious and thus has not been able to participate in decision-making or express her goals. She recently completed an advance directive with Frank stating that she wished to "withhold any and all medical interventions that are not likely to improve my life."

She is continuing to decline and will likely die if aggressive medical interventions are not done. Frank has approached the medical team about the possibility of starting her on ECMO in order to give her a chance. The medical team is concerned that once they start Ms. Claudio on ECMO, they may not be able to take her off, and they wonder whether that is a state or quality of life she would find acceptable. They recognize that ECMO is likely the only intervention that could prevent her imminent death, but they are worried about violating her advance directive regarding interventions that cannot "improve" her life.

Ethical Musings

Interventions and Goals

The One Question to Ask About ECMO and Other Medical Miracles

By Ryan Pferdehirt, D.Bioethics, HEC-C, Vice President of Ethics Services, Rosemary Flanigan Chair

Clinical ethics consultation can often seem obscure. Many healthcare professionals and patients are not sure what to expect. What types of questions will the ethicist ask?

As a clinical ethicist, one question that I will sometimes ask patients when they are in the hospital — and one that they are not always prepared to answer — is: *Why are you here?* While this is not my usual choice of words, the idea behind it is true. Other ways of asking the same thing might be: *What are your goals for this hospitalization? What are you hoping to achieve or experience because you are here?*

What Is Nonmaleficence?

Modern healthcare is capable of many things, but it is important to keep those capabilities in perspective and focused on providing benefit for the patient. This is a foundational aspect of the principle of nonmaleficence, which holds that it is the responsibility of "the physician to weigh the benefits against burdens of all interventions and treatments, to eschew those that are inappropriately burdensome, and to choose the best course of action for the patient" (Varkey B. Principles of Clinical Ethics and Their Application to Practice. *Med Princ Pract.* 2021;30(1):17–28. doi:10.1159/000509119).

Avoiding harm is more than just preventing death. The benefits of medical interventions must be weighed against their burdens, and only then can an appropriate course be determined. This is why we ask patients why they are in the hospital — what they are hoping to achieve.

What Are the Patient's Goals?

If the goal is simply life for the sake of life, regardless of the state or quality of that life, then certain interventions may be appropriate. But if the goal of hospitalization is to make a full recovery, to return to what the patient would consider their "normal life," then those same interventions may not be as beneficial as originally thought. Some patients have even said they are not sure why they are in the hospital at all, only that it is what they do when they are sick and/or scared.

It is important to understand a patient's goals in order to determine which interventions are beneficial and which would be excessively burdensome. We do not want to do things simply because we *can*.

This also brings in the concepts of intention and goals behind medical interventions. What is an intervention hoping to achieve? When a patient has cancer and begins chemotherapy, the goal of the chemotherapy is to eliminate or reduce tumors so that the patient can recover and improve. That is the intention of the treatment. But if that goal is no longer possible — if the cancer is not responding — then the intention needs to be reassessed.

We Can, But Should We?

It is because of this mentality that I will raise concerns when we are discussing beginning ECMO for a patient. It goes back to the famous adage of medical ethics: *Just because we can, does that mean we should?* Yes, we can do incredible things medically for patients, but they are not always the most appropriate interventions for the patient and their goals.

ECMO is an extraordinary medical breakthrough that can support patients and keep many alive who otherwise would have died — but that brings us back to the question of intention. Are we starting ECMO because it can help the patient recover? To improve? To benefit? Or is it simply because we have no other options?

Once we start ECMO, what then? When ECMO is being discussed as a possible intervention, it is important to remember the intention behind it. It is important to remember the "why."

Source

https://pubmed.ncbi.nlm.nih.gov/32498071/

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