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FROM THE INSIDE

The ontology of being ventilated—a less mechanistic and more holistic understanding

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"Breath, you invisible poem!
Pure, continuous exchange
with all that is, flow and counterflow
where rhythmically I come to be".
Rainer Maria Rilke, Sonnets to Orpheus II

Mechanical ventilation (MV) is a cornerstone of the treatment of respiratory failure, and the focus of respiratory science is, of necessity, related to physiologic, diagnostic, and therapeutic aspects. This viewpoint, however, is directed at a more holistic approach, tuned into an ontological perspective of breathing with mechanical ventilation. Ontology studies the nature of existence and reflects, by that, all aspects of our *being in the world*. In our reflection, we ask whether the ontological integrity of a human being is affected when being ventilated: does the survival of critical illness with a device replacing the gas exchange of the native lungs (they are to some extent still responsible for the gas exchange) lead to a transformation of self? A thoughtful ontological approach might lead to a more ethically respectful approach to our patients.

A *phenomenological ontology of breathing* came into a philosophical scholarly focus—basing on the German Philosopher *Edmund Husserl's* conception of the phenomenon of breathing not just as a natural scientific entity, but additionally as a philosophical question with ontological, experiential, spiritual, bodily, mental, poetic, elemental, ethical, voluntary, and mystical dimensions.

We aim to take the following approach: Is a human being, under the circumstances of MV and therefore separated from *'the lived body of breath experience'* [1], in another condition of Being? And, if yes, what does this mean from a holistic point of view? Our hypothesis is that MV has an enormous impact not only on the respiratory system or the brain but also on *'the lived body's experiential openness to the world and Being'* [Merleau-Ponty, 2]. We are convinced that a reflection on such an approach might be important for clinicians working in respiratory medicine caring for our patients as human *beings-in-the-world*.

Ontologic–phenomenology of breathing and breathlessness

Husserl defined the discipline of phenomenology *'as the study of structures of experience, or consciousness'*, emphasizing the directness of experience towards things in the world. In *Ideas I Husserl* intended to integrate consciousness such that it is a subjective consciousness *of* or *about* something in our experience, directed toward objective things only *through* particular concepts, ideas, and thoughts. Phenomenology is interested in the fundamental problem of accurately describing the essential features of *'everyday lived experience'*. Breathing, in its tangible dimensions, is phenomenologically an important entity, and we should include it in our attempt at a holistic approach towards *to be breathed.*

Breath, as an "*ephemeral materialization of air at the interphase between body and world"* [3] was always present in Eastern Philosophy, early religions, and traditions like *atman* (Soul, the Self in Indian philosophy, 'Breath' in German language is 'Atmen'), *πνεῦμα* (Pneuma in ancient Greek = air, breath, essence), רוּחַ *rûaḥ* (Ruach in Hebraic = 'Soul, Spirit'), *spiritus* (in Latin = spirit, soul). These templates express that breathing was understood

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as a particular and spiritually loaded aspect of human life or, more generally, of human existence. Additionally, various patterns of breathing might be interpreted as manifestations of unconscious conflicts (i.e., birth trauma, separation from the maternal body), or other structural anxiety. These aspects raise the question of the implications of dyspnea, or, in the extreme, the inability to breathe independently and maintain the exchange of the 'outside-of-me'. A disease-based dyspnea is characterized by fear of life, helplessness, shame, or feelings of inferiority damaging the autonomous exchange with the world. Ventilation by a machine keeping the patient alive, replaces natural breathing by artificial devices and thereby disconnects the person from being part of the world. Also for patients with chronic dyspnea or fatigue, MV may represent a vital, life ensuring help and—whether temporary or not—an appendage to their body, which will not necessarily lead to another perception of "Being or Feeling-key issues".

Being ventilated and the self

Respiratory failure requiring MV replaces the independent, individual ability to maintain the metabolic balance between energy (oxygen) and the 'waste' of energy production (carbon dioxide)—in a broad spectrum of invasiveness of MV and of interfaces between patient and ventilator. A device, the ventilator, takes control over life from the individual being, transferring it to a soulless machine. Breathing is not only a *function* but a *dimension* of Being. *"Breathing…is not only essential for biological survival; it assumes a privileged function…in developing self-awareness…leading to…an authentic 'individuation', a never ending dialectic…vigilance…"* [4]. Taking the elementary interference of a mechanical ventilator with the Self and Embodiment of the 'object' into consideration, emphasizes that on a phenomenological level, such an interference is likely to have enormous impacts, not describable by laboratory or physiologic values, or classic outcome parameters. A change in the lived body's experience to world by being ventilated could not sufficiently be represented in psychological tests or classical 'quality-of-life' surveys. Specifically, the experience of ventilator asynchrony as a "fight to breathe" or a "fight against the machine" could be linked to existential fear.

Of note, a qualitative study by in-depth narrative interviews in patients with dyspnea identified four items that illuminated the phenomenon of breathing during and after MV: existential threat, tough time, *amorphous and boundless body*, and getting through [5]. One patient expressed: *"…I was more of an amoeba lying there in a storage…"*. It was stated from these interviews that *"being unable to breathe on one's own makes the borders between one's self and others, between the person and the world hazy or unclear"* as being in a sort of in-between space. Patients often report—despite the effects of analgosedation or delirium—five important themes after MV: maintaining human dignity, accepting the situation, enduring the difficulties, inadequate interaction, and *a sense of unreality*.

What might be the implications for clinical practice?

The impact of breathlessness and MV on the patients' experiences is obviously tremendous, and sensible interventions to improve care should include:

- Consideration of the above discussed consequences for MV indications
- Encouraging patients to feel a sense of self through simple reorientation to person, body, and place in the early days after extubation
- Careful communication with families and—if possible—patients
- Sensible query and documentation of 'air hunger'

Including the patients in this process might help transform them from the experience of being a human being well taken care of and not as hibernators in a cocoon. Whether these measures are able to lessen the being a different person ontologically mutated, will have to be determined in the future. Our attempt is narrative and leaves more questions than answers, since the other side effects of care may additionally intertwine with the experiences of being ventilated.

Based on *Husserl's* and *Merleau-Ponty's* concepts, we knock on an 'ontologic' door, not knowing what is behind. There, we could find a good path for a better understanding of our patients in clinical practice. Reflecting on the role of human *beings-in-the-world* may help to better understand the existential impact of being separated from "*the lived body of breath experience"* and, by that, open the door to more comprehensive patient-centered care.

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