

**Instructions: Choose one of the 2 case studies below to read and answer the corresponding reflection questions for that scenario. Submit to my dropbox and be prepared to discuss your responses in class.**

### **Case 1 – Is it Okay to Change Your Mind?**

A 90-year-old female, Mrs. Ruth, is admitted to hospital from home after sustaining a hip fracture. She has a history of chronic obstructive pulmonary disease on home oxygen and moderate to severe aortic stenosis. She undergoes urgent hemiarthroplasty (hip surgery) with an uneventful operative course.

Unfortunately, on postoperative day 4, the patient develops delirium with respiratory failure secondary to hospital acquired pneumonia and pulmonary edema. Her goals of care were not assessed pre-operatively. She is admitted to the ICU for non-invasive positive pressure ventilation for 48 hours, and then deteriorates and is intubated. After 48 hours of ventilation, it was determined that due to the severity of her underlying cardio-pulmonary status (COPD and aortic stenosis), ventilator weaning would be difficult and further ventilation would be futile.

The patient's daughter is insistent on continuing all forms of life support, including mechanical ventilation and even extracorporeal membranous oxygenation (ECMO) if indicated. However, Mrs. Ruth's delirium clears within the next 24 hours of intubation, and she is now competent, although still mechanically ventilated. She communicated to the ICU team that she preferred 1-way extubation (removal of the ventilator) and comfort care. This was communicated in writing to the ICU team and was consistent over time with other care providers. The patient went as far to demand the extubation over the next hour, which was felt to be reasonable by the ICU team.

The patient's daughter was informed of this decision and stated that she could not come to the hospital for 2 hours, and in the meantime, that the patient must remain intubated. At this point, the ICU team concurred with the patient's wishes, and extubated her before her daughter was able to come to the hospital.

The daughter was angry at the team's decision and requested that the patient be re-intubated if she deteriorated. When the daughter arrived at the hospital, the patient and daughter were able to converse, and the patient then agreed to re-intubation if she deteriorated.

1. Who do you think should make decisions in this situation? Should the ICU team have extubated the patient? **I believe the patient should be making the decisions for her care as she knows her body best. In the instance of her deterioration and staff agreement she seemed to be able to make the "right" decision. In another circumstance, I can see the daughter making decisions if her mom wasn't able too. Sometimes family members have to be counseled on what's best for the patient and how to detach with love for the best.**

2. Do you think the patient should be allowed to change her mind? **I believe the client has the right to change her mind because these are decisions that cannot be taken back, but it should also be in writing in case the client is not in the right state of mind to do so. i.e. a DMOST or a medical proxy.**
3. Does the change in the patient's decision mean that she lacked the capacity to make the decision in the first place, or that she was not well informed? **Yes, once she was in a delirium state it's hard to make rational decisions but at what point do you take that authority away. She was also not well informed if she was, the client could have that conversation with her daughter and medical team about terms of care.**
4. The patient's goals of care were not assessed preoperatively. When do you think would have been the ideal time to have that conversation with the patient? **The ideal time to have that conversation with the client would be when she was fully conscious and alert before day 4 when the delirium started and at the beginning of these diagnoses.**