

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 the one to make decisions in this situation. Within healthcare, it is always desired to have the patient maintain autonomy within their care as long as it is appropriate for their level of consciousness. I do believe the ICU team should have extubated the patient due to the resolution of her delirium and her ability to effectively communicate her wishes for care in which the ICU team concurred and believed was reasonable.

2. Do you think the patient should be allowed to change her mind?

I believe the patient should be allowed to change her mind. If Mrs. Ruth is in a sound state of mind and is able to make rational and thoughtful decisions about her care, she should be allowed to alter what she wants.

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?

I do not believe that the patient's change in decision means that she lacked the capacity to make the decision in the first place. While standing firm on a decision for care facilitates confidence in that decision, after speaking with family and going over options again, feelings and desires may change. Ultimately, the state of mind and decision-making abilities should be monitored for Mrs. Ruth, but if the ICU team believed she was fit to make decisions initially, they should support the change as well so long as she does not display a change in mind. With this change of decision, the ICU team should be sure that Mrs. Ruth does not have any additional questions about her options of care and should provide any additional information and teaching that is necessary.

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?

An ideal time to have a conversation of goals of care would be on admission or soon after that if they do not already have a living will or advance directive expressing their wishes. Decompenation can occur at any time and it is important to know what the patient would want in terms of care before that occurs. Having a healthcare proxy or power of attorney is beneficial, however, it is preferred to maintain a patient's autonomy and have them make as many decisions as is appropriate for their abilities at that time.