

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

## Case 2 – Nutrition at the End of Life

Mrs. Green is a 75-year-old patient with renal failure, currently on dialysis, who also has COPD, moderate dementia, diabetes and a new diagnosis of stage one breast cancer. There is also a history of depression according to the family. She has been admitted to your ICU after falling down her stairs at home and is in critical condition with multiple fractures to her hip, ribs, wrists and neck. Mrs. Green does not have the capacity to make her own medical decisions and has recently started to refuse eating. Upon discussion with GI Specialists, the team agrees that the patient is not an appropriate candidate for a PEG (feeding) tube. The patient's daughter, who is her POA, insists that the you proceed with the placement of the PEG, stating that if the tube is not placed, she will contact her lawyer and proceed with legal action against the physician and hospital.

1. What documentation would help you to determine what the patient's wishes are?

**Advanced directive**

2. If the medical team does not feel that a PEG tube is medically appropriate, do you think the daughter can demand that it be placed and expect the team will provide it?

**I do not believe that, even with the daughter demanding, the healthcare team will insert a PEG tube on this patient due to the risk of aspiration, infection etc. that could arise and create more of an issue than without it.**

3. What do you think some complications of PEG tube feeding may be at end of life?

**Infection could be a big risk for this patient after surgery for PEG tube because of her age and condition; the patient could be intolerant to the nutrition provided; she may even try to pull the tube out since she has dementia and is not fully aware of what is happening; a big risk for aspiration**

4. Families often struggle with the concept of stopping nutrition/hydration at the end of life. Why do you think that may be?

**I believe that it is hard for family members to come to terms with the idea that their loved one is nearing the end of life and that slowing down/stopping nutrition is a part of that process. Family members may think that if they are fed more then it will help them prolong their life but in reality it does neither prolongs or improves their lives.**