

Yana Quel, 2/21

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?
 - o The main question I have is whether the daughter is the PoA. If she is not, it is not up to her to make any decisions that the healthcare team legally are REQUIRED to follow. Otherwise, I feel as if the pt can make the decision since she has not been delirious for over 24hr and has been consistent w/ multiple HCPs involved in her care.

- o On the other hand, if the daughter is the PoA, unfortunately (I guess this is subjective, but I think unfortunately) the team must follow her decision making.
 - o In both scenarios, the team should have waited to extubate her until the daughter arrived in my opinion. If she became unstable on comfort care and passed without the daughter there, it would have been really sad and unfair. Although back to if the daughter is not the PoA and the pt is deemed to be competent in making decisions, then it does not matter and they did the right thing BY the pt by allowing her wish to happen.
2. Do you think the patient should be allowed to change her mind?
- o I do think the pt should be allowed to change her mind, but not in terms of getting re-intubated. I think the daughter, while very understandably so, is letting her emotions get in the way of the fact that her mom is NINETY YEARS OLD, her procedure didn't work, and there isn't much left for her in terms of a good quality of life. I think in a good-intentioned way, she coerced her to get re-intubated if she started to decline again. At the end of the day it is the pt's life she is making decisions about and it allows her to gain independence back if she has capacity to make her own decisions about her medical care moving forward.
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?
- o I think it is a case of not being well informed. Once she stopped being delirious, she regained capacity & competency to make her own decisions. Not being well informed could have been dependent on who is the PoA and what her previous advanced directive stated for her wishes.
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?
- o Since the procedure was urgent and not emergent, I think after she was stabilized in the ED and was admitted to a bed, after pain management took place (assuming she was not under the influence of narcotics or opioids) that would have been a good time to talk about post-op care and options in a manner that she could have consented to. This also would have been a good time to talk about this without the influence of her daughter.

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?
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?
3. What do you think some complications of PEG tube feeding may be at end of life?
4. Families often struggle with the concept of stopping nutrition/hydration at the end of life. Why do you think that may be?