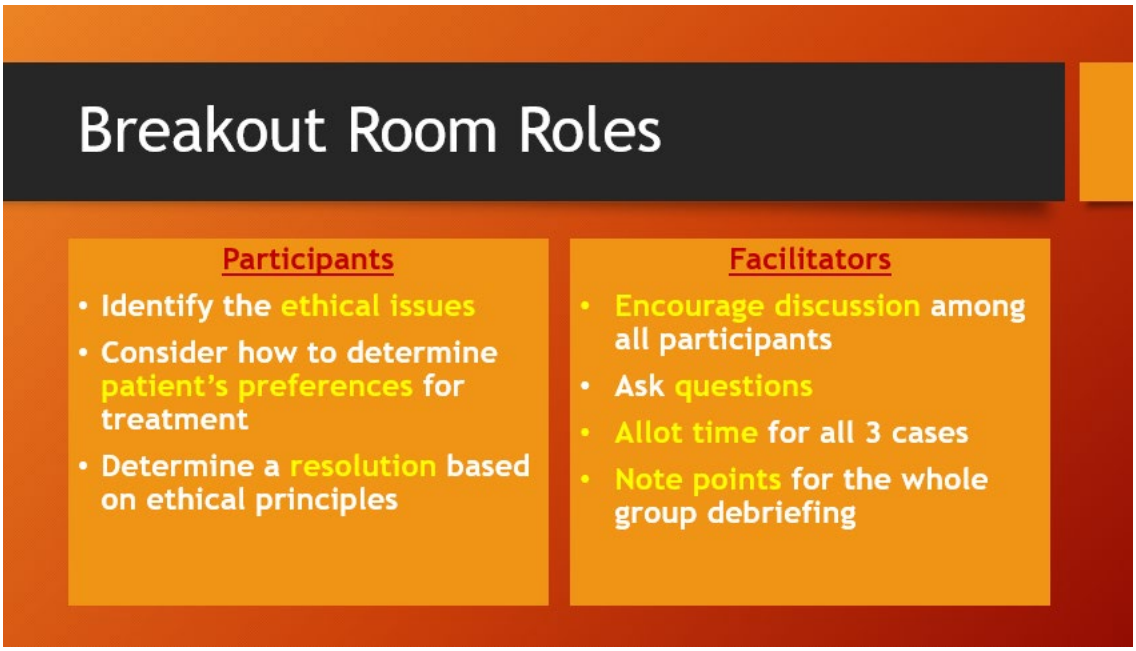
Montgomery County Palliative Care and End of Life Coalition
National Healthcare Decisions Day
"Ethics in Death and Dying"
Facilitated by Alvin Reaves, III, MD and Beth N. Peshkin, MS, CGC
April 16, 2024



Reminder: We have about 30 minutes to discuss all 3 cases in the Breakout Rooms!

Case 1: Patient without Decision-Making Capacity (DMC), no Advance Directive (AD), no designated Health Care Agent (HCA)

"[Mr. Brady is a] 51-year-old man admitted to the ICU from another hospital with severe…brain damage several days after an unanticipated post-operative cardiac arrest. After several weeks, he is judged to be in a vegetative state, but a subsequent neurology consultation advises that a persistent vegetative state cannot be diagnosed before three months. The patient's male partner of 20 years…is sure that the patient would not want to live in this condition [although there is no documentation of Mr. Brady's wishes]. However, the patient's sister adamantly insists that life-prolonging measures continue for the full three months. She threatens the partner with legal action and says she will hold him forever responsible if her brother dies."

(Adapted from Forrow L, https://immattersacp.org/archives/2008/02/ethics.htm)

- What ethical concerns does this case raise?
- How would an advance care directive and MOLST have been helpful?
- How does the healthcare team determine what Mr. Brady would have wanted?
- What is a satisfying resolution to this case?

Case 2: Patient with impaired Decision-Making Capacity (DMC), outdated Medical Orders for Life Sustaining Treatment (MOLST)

- **Mrs. Fanning is an 80-year-old widow who was diagnosed with inoperable stage IV lung cancer that spread to her bones 3 months ago. She also has diabetes and high blood pressure. For the last 2 years, she has resided in an assisted living facility, mainly because of severe osteoarthritis which limited her mobility and ability to fully care for herself. She adeptly used a walker and was fully cognizant, engaging in many of the community social activities. Several times a month her two grown children and her four grandchildren would visit her.**
- **After developing marked shortness of breath, Mrs. Fanning was admitted to the hospital for treatment of pneumonia and appeared to be improving. However, three days later, she developed a high fever and sepsis. Her oxygen levels worsened despite ongoing treatments. She developed acute kidney failure and became disoriented. To prevent imminent death, dialysis and intubation would need to be performed. The healthcare team felt that it was unlikely she could ever be extubated, nor would she be able to return to her residence. After much discussion, her daughter, the designated healthcare agent, and her son ask that she be allowed to die a natural death and be kept comfortable. They request no interventions and comfort care only.**
- **Mrs. Fanning completed a MOLST and an advance directive when she moved into the assisted living facility but never updated it after being diagnosed with cancer 3 months ago. On those forms, she indicated that she would want all medical interventions.**

(Adapted from Georgetown University School of Medicine Health Care Ethics course)

- What ethical concerns does this case raise?
- Does Mrs. Fanning have the capacity to make healthcare decisions at this point? How is that determined?
- How would the MOLST be used to guide the next steps for Mrs. Fanning? Can the MOLST be overridden? If so, through what process?
- In your opinion, what is a satisfying resolution to this case?

Case 3: Patient without Decision-Making Capacity (DMC) and no designated Health Care Agent (HCA) or surrogates

"A 78-year-old woman with a history of multiple strokes and severe dementia is admitted to the medical ICU from an extended-care facility for treatment of septic shock. The patient never completed an advance directive and has no family members or friends. A number of urgent management decisions must be made, including intubation. The attending physician believes that shifting to comfort care is appropriate." (*Wiesen J, et al. Cleve Clin J Med 2021;88:516)*

- How does the "best interest" standard apply here given that medical treatment will not be effective?