Voluntarily Refusing Nutrition and Hydration in Nursing Home Residents

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Introduction

Summary of the Case Study

Mr. K, an 84 year old white male, had been living in a nursing home since May 2008 after falling frequently at home and was unable to take care of himself. His wife died from ovarian cancer in 2006. In the nursing home, Mr. K had a left-sided ischemic stroke with dense right sided hemiparesis and dysphagia. Although he was fully informed the risks of aspiration, he refused pureed diet with nectar thick liquids and signed the waiver for a regular diet. Mr. K remained wheelchair bound and required moderate to maximum assistance with personal hygiene. He was also incontinent of urine and bowel.

Mr. K was hospitalized twice for exacerbation of congestive heart failure and aspiration pneumonia after the stroke. He had advanced directives in his chart, and he was "Do Not Resuscitate" (DNR) in the nursing home. He had always refused a gastrostomy tube placement; however, when he was discharged to the nursing home after the second hospitalization, he had a percutaneous endoscopic gastrostomy (PEG) tube. He only consented to have one can of nutritional supplement bolus feeding via the PEG at night before he went to bed, and he continued to consent to a regular diet. It seemed that he could take the regular diet fine without any signs and symptoms of aspiration at that time. His daughter often brought his favorite foods from home, and the dietary department prepared his favorite foods too. However, nothing seemed to work. Many times, Mr. K would not swallow the foods, or he simply would spit it out.

Mr. K was not confused. He read his favorite books and attended the worship services held by the local Baptist church in the facility every Sunday morning. He

sometimes even led the hymn singing from his wheelchair. He still refused to eat and drink or increase his tube feeding. He became weaker and weaker. He lost more than 20 pounds within four weeks, but he refused to be sent to the hospital for further evaluation. A week after he was discharged to the nursing home, Mr. K started to refuse his nightly bolus tube feeding. His family was notified, and they demanded the tube feeding be increased. But Mr. K kept refusing. He stated, "There is no point for that. Life is no longer worth living. I will never be the same man again. Please let me go! It's time for me to meet with my wife."

General Ethical Dilemma

Ethical dilemmas occur when "a different moral problem has two or more mutually exclusive, morally correct courses of action" (Stinson, Godkin & Robinson, 2004, p. 39). There are several ethical dilemmas in this case. However, this paper will focus on the following ethical dilemma: Should Mr. K be allowed to voluntarily refuse nutrition and hydration to hasten death?

Quill, Lee, and Nunn (2000) noted that a patient who is physically capable of taking nutritional nourishment yet voluntarily refuses it makes "an active decision to discontinue all nutrition and hydration to hasten death" (p.489). In this case, there could be two different courses of action used to either please Mr. K's family by increasing his tube feeding amount and frequency to prolong his life, or honor Mr. K's autonomy by allowing him to refuse the nutrition and hydration and die. This provided a moral dilemma for the patient, his family, and the healthcare providers involved in his care.

Stakeholders in the Issue

Primary stakeholders are the patient and his family, although the opinions from the healthcare providers are also very important. Healthcare providers' failure to provide information about alternative care options such as palliative or hospice care and the process and the consequences of voluntarily stopping nutrition and hydration, will result in harming the patient. In addition, the clinician's failure to consider the opinions and recommendations of the nurses, social workers, therapists and other care givers may also result in harming the patient if the patient is forced to participate in any interventions about which serious moral and ethical concerns can arise. Other stakeholders may include society, legislators, and the legal system.

Ethics Section

Clarification and Expansion of Ethical Dilemma

The ethical theory of deontology , also called obligation-based theory, was developed to "explain what actions are considered right or wrong according to balance of their good and bad consequences" (Stinson et al., 2004, p.39). It is based on the belief that some features of actions other than the consequences make actions right or wrong. It emphasizes on duty or obligation. Deontological theory examines the action for "its intrinsic quality regardless of consequences" (Stinson et al., 2004, p. 39). There are four major principles in Deontology: autonomy, nonmaleficence, beneficence, and justice, (Lo, 2009).

The concept of autonomy includes the ideas of "independence, self-determination and freedom" (Lo, 2009, p. 11). Allowing patients to make their own decisions about their health care is to honor their autonomy. Autonomy also dictates that patients have

the right to accept, refuse or stop any medical interventions (Iglewicz, Zisook, Lebowitz, & Irwin, 2009).

Beneficence refers to "the duty to do good, whereas nonmaleficence means to the duty to prevent or do no harm" (Mueller, Hook, & Fleming, 2004, p. 554). Justice refers to the duty to treat individuals fairly (Lo, 2009). Schwarz (2007) argued that the moral obligation to honor a patient' s decision to withdraw life-sustaining treatment is based upon "the patient's right of autonomy and self-determination and the corresponding duty of health care providers to respect that autonomy-providing the patient's decision is informed and voluntary" (p.1289). People who choose to voluntarily refuse nutrition and hydration may want to regain or maintain some control over their situation, and healthcare providers should respect their decisions (Morrow, 2008). Several reasons that patients voluntarily decide to refuse nutrition and hydration include: "being ready to die, believing that continuing to live is pointless, a sense of poor quality of life, and wanting to control the manner of death" (Ganzini et al., 2003, p.363). Ganzini et al. (2003) also stated that unbearable physical suffering did not seem to be the reason for the people to make such a decision.

In addition, Quill et al. (2000) stated that the right of mentally competent, well informed patients to refuse life-prolonging interventions, such as artificial fluids and nutrition, is well documented in the ethical and legal literature. Therefore, voluntarily refusing nutrition and hydration in the mentally competent, well informed patient could be considered as an extension of that right (Stinson et al., 2004).

The second ethical principle to consider is beneficence, meaning to do good, inflicting no harm, promoting good, and preventing any harm (Stinson et al., 2004). Stinson et al. argued that the patients who chose to voluntarily stop nutrition and hydration may experience thirst, hunger, and increasing suffering, but the majority of the patients remained comfortable. Decreasing nutritional intake helps to produce endorphins, and dehydration "leads to an increase in dynorphin level leading to increased comfort levels in patients" (Stinson et al., 2004, p.41). However, if the medications are not adjusted for pain and for depression, the decision to proceed with voluntarily stopping nutrition and hydration may not be a thoroughly informed decision (Stinson et al., 2004). Depression, when severe, may influence a patient's decision making ability. If depressed patients are treated effectively and successfully for their depression, they may choose to eat and drink and to continue to live (Ganzini et al., 2003).

Argument for and Against Action

Treating patients with respect entails several obligations (Lo, 2009). Healthcare providers must respect the medical decisions of their patients and promote the patients' autonomy. When mentally competent, well informed patients make decisions regarding their medical interventions, either accept or refuse, healthcare providers should respect their choices, if their choices do not raise any serious legal or ethical concerns (Lo, 2009). In addition, the Code of Ethics for Nurses (American Nurses Association [ANA], 2001) stresses that nurses have an obligation to protect and treat patients ethically by promoting their autonomy.

The ethical guideline of nonmaleficence forbids healthcare providers from providing insufficient and ineffective therapies and treatment interventions, or from

acting selfishly or maliciously (Lo, 2009). When patients make decisions unwisely, or decisions that elicit serious ethical and legal concerns, healthcare providers have a responsibility to help the patients deliberate, to make recommendations, and to try to persuade the patients to re-consider their decisions (Lo, 2009).

In the United States, there are a number of legally accepted and morally justified end-of-life practices available to the patients with terminal illness or with irreversible health conditions (Faber et al., 2006). Voluntarily stopping nutrition and hydration by self-determined, well informed patients is one of them. Numbers of people have died in American hospitals as a consequence of someone's decision to withhold or withdraw life-sustaining medical treatment (Schwarz, 2007). There has been a "consensus in the medical literature that patients have a moral and legal right to have their healthcare providers to adhere to their wishes in regard to various forms of medical treatment" (Faber et al., 2006, p.560). This medical literature particularly discussed patients' rights to refuse various forms of medical interventions in regard to end-of-life treatment (Faber et al., 2006). In addition, in 1990 and 1997, the United States Supreme Court reinforced that a mentally competent, well informed patient could reject life-sustaining medical interventions, including artificial nutrition and hydration (Stinson et al., 2004).

Withholding or withdrawing life-sustaining interventions are broadly known as "allowing to die" (Faber et al., 2006, p.563). Voluntarily refusing nutrition and hydration is made by a mentally competent, well informed patient who consciously chooses to "refuse further nutrition and hydration with the intention of hasting his or her death" (Schwarz, 2007, p. 1291). Depending on the patient's preexisting physical condition and disease state, death usually occurs within one to three weeks when the fast starts. The

most significant advantage of voluntarily refusing nutrition and hydration is that it solely relies on a mentally competent patient's personal decision and determination to control his/her own end-of-life experience (Schwarz, 2007). Voluntarily refusing nutrition and hydration in mentally competent patients does not require the permission from their physicians, and they may change their mind to continue nutrition and hydration if they wish (Mueller et al., 2004).

Furthermore, evidence has shown that the cessation of eating and drinking is a normal part of the dying process. It typically occurs days to weeks before death. When the body gets mildly dehydrated, the brain releases endorphins that act as natural opioids, causing euphoria, and it often helps to decrease pain and discomfort (Morrow, 2008). However, the disadvantages of voluntarily stopping nutrition and hydration include feeling hungry, dry mouth, and end-of-life delirium (Schwarz, 2007). Therefore, from an ethical perspective, patient autonomy, beneficence, and nonmaleficence are the principles that support a patient's right to refuse or request for the removal of any type of treatment, including artificial nutritional supplement and hydration. From a legal aspect, a person's right to "self-determination as provided in the 14th Amendment to the US Constitution also grants this right to patients" (Faber et al., 2006, p.563).

Despite the legal and moral consensus of this issue, some health care providers still do not feel comfortable agreeing with a patient's decision to stop treatment or refuse nutrition and hydration. Therefore, it is suggested that when a patient asks about the options to hasten dying, all members involved in the care of this patient should be informed. It is particularly important to consult the mental health specialists who are "skilled in assessing decision-making capability to assess the patients, especially when

the patients without terminal illness or irreversible health conditions request voluntarily stopping nutrition and hydration" (Stinson et al., 2004, p.42). The rationale is that people who have major depression will have altered ability to make the appropriate decisions. It is also difficult to recognize depression in frail elderly patients (Ganzini et al., 2003; Schwarz, 2009).

Furthermore, palliative care or hospice care should be recommended to mentally competent, well informed patients who express the wish to die by stopping nutrition and hydration (Quill, Lee, & Nunn, 2000). Palliative care is different from hospice care, in that palliative care attempts to "relieve uncomfortable symptoms and improve the quality of life for severely ill patients and their families" (Quill, 2004, p.2029). In addition, palliative care is offered alongside with active treatment of a patient's underlying disease, regardless of the prognosis. Hospice care, in contrast, is palliative care for "terminally ill patients in the last six months or less of life who are no longer seeking treatment to cure their condition" (Schwarz, 2009, p.54). After the initiation of a fast, patients may experience discomfort, and providers in palliative care/hospice care are able to provide comfort care and emotional support to these patients and their families.

Other Way of Reasoning

Nurses, including advanced practice nurses, have the unique responsibility to provide care to their patients as well as the patients' families. Nurses often experience ethical issues in their daily practice and in an ever-changing healthcare environment (Stinson et al., 2004). The Code of Ethics for Nurses (ANA, 2001) stresses that nurses treat patients ethically. One of the most important roles for the nurses is that of patient advocate. Advocacy is "accountability to patients and involves listening to patients and

their wishes, and helping them find truth" (Stinson et al., 2004, p. 42). Nurses not only act as patient advocates, but also have the responsibility to act on this realization by assisting patients in their search for autonomy.

As nurses collaborate among physicians, patients, families, and other healthcare providers, it is very important for nurses to communicate effectively with different parties. Effective communication between patients and their family members also maximizes patients' autonomy because family members may not grant their loved ones' wishes in regard to the end-of-life decisions (Mueller et al., 2004). Research studies have found that physicians frequently fail to spend adequate time with their patients listening to their concerns. Instead, they often interrupt their patients when they begin to describe their reasons for advice (Mueller et al., 2004). It is not surprising that ethical dilemmas often arise because of the poor communication. Since nurses spend most of their time with their patients, they may easily develop a good relationship with their patients and the patients' families. Patients and their families often feel more comfortable discussing their treatment choices with nurses. Recent literature on family satisfaction with end-of-life care in nursing homes illustrates the importance of good communication and information sharing between the nursing staff and family members (Gjerber Forde, Pedersen, & Bollig, 2010).

Legal Issues

The right to refuse nutrition and hydration comes from "the fundamental right of competent, well informed patients to refuse medical treatment and be free of bodily invasion" (Stinson et al., 2004, p.40). Because the consequence of voluntarily refusing nutrition and hydration is death, questions may arise, such as "Is this considered

suicide?" If it is considered a suicidal attempt, medical healthcare providers may not legally be able to honor the patient's wish. Legal cases involving voluntary refusal of nutrition and hydration are very limited (Schwarz, 2007; Stinson et al., 2004). According to Cantor (2006), voluntarily refusing nutrition and hydration has some "earmarks of suicide, and a health care provider's cooperation, such as providing palliative care, smacks of assisted suicide" (p. 110). However, many other healthcare providers believe that voluntarily refusing nutrition and hydration is the decision made by competent, well informed patients who want to control their medical interventions, and therefore is legal. The common elements between "facilitation of voluntarily refusing nutrition and hydration and assisted suicide make the legal status of voluntarily refusing nutrition and hydration somewhat uncertain" (Cantor, 2006, p. 121).

The majority of the literature distinguishes between voluntarily refusing nutrition and hydration and physician- assisted suicide or euthanasia. Harvath et al. (2006) stated that voluntarily refusing nutrition and hydration was perceived as a much more natural process, and it carried less emotional burden for the family. It was perceived as "letting go of life" (p.8). On the other hand, in physician-assisted suicide, patients "personally terminate their lives by using an external means provided by a clinician, such as a lethal prescription" (Mueller et al., 2004, p.557). In euthanasia, the clinician "directly terminates the patient's life by using a lethal injection" (Mueller et al., 2004, p.557). There is no ethical consensus on the acceptability of these two. It is illegal for physician-assisted suicide and euthanasia in the United States, except in the state of Oregon, where physician-assisted suicide is considered legal. Both physician-assisted suicide and euthanasia require that patients be mentally competent, and physician involvement is

necessary (Quill, 2004). There is a growing consensus on the acceptability of voluntarily stopping eating and drinking in patients who are mentally competent to make such decision. It is considered legal in the United States, and it does not require the physician involvement, although it is desired (Quill et al., 2000; Quill, 2004).

Personal Decision

This author does not support that voluntarily refusing nutrition and hydration is an approach to end one's life in general. It is against her person belief and values although she believes that respecting patients' choices and honoring their wishes are ways to promote their autonomy. She does not agree that allowing patients to die by suggesting they voluntarily stop nutrition and hydration is moral, especially with the younger patients. However, in this case, she supported her patient's decision of voluntarily refusing nutrition and hydration. This patient had been expressing his feelings to the nursing staff, such as "life is pointless", "I will never be the same person again", and "I want to be with my wife". In addition, this patient was in his eighties, and he was mentally competent to make any decisions in regard to his medical interventions. Also, he did not have any signs of depression. He stated that he had a good life, and he was ready to die. It seemed that he had been deliberating this decision for a while. He wanted to control his end-of-life experience. Therefore, his wish should be honored in order to promote his autonomy. Care plan meetings were conducted several times with the patient, his family, the social worker, primary care providers, geriatric psychologist and geriatric psychiatrist, the speech therapist, the nursing staff, and the administrator. Finally, his family members agreed to allow the patient to stop his nutrition and hydration completely. This author believed that hospice or palliative care would be important to

provide end-of-life care and to this patient. With permission from the patient and his family, hospice care was consulted.

Moreover, this author also believes that it is very important to provide emotional support to the patients and their families during the end-of-life care. When there is a conflict between the patients and their families in regard to the choice for the treatment interventions, the family needs to respect their loved one's decisions, especially when their loved one is mentally competent. Patients and their families are often clear that it is not death that they are afraid of, but the process of dying that scares them. They are often emotionally unable to handle the prolonged suffering their loved ones might have to experience (Mamdani, 2010). This author spent a lot of time with the patient's family members and assured them that palliative/hospice care providers would provide comfort care to the patient, and he would not suffer. This patient died peacefully on the 11th day after all the nutrition and hydration were stopped.

Despite the growing legal, moral, and ethical consensus on voluntarily stopping nutrition and hydration, some healthcare providers with strong moral or religious beliefs about the sanctity of life may still find the act of withholding or withdrawing life-sustaining treatments personally troubling, particularly the choices that patients make to hasten death (Schwarz, 2007). If such situations happen, this author agrees that healthcare providers have the obligation to "inform the patients/families of their moral reservations, confirm the patient 'right to make their own treatment choices, and facilitate transfer of the patient's care to another clinician who is able to support the patient's choices" (Mueller et al., 2004; Schwarz, 2007, p. 1289).

Summary

Voluntary refusal of nutrition and hydration in competent, well informed patients has been recognized by the courts as a legally supported option to hasten death. Cognitively intact patients choose to voluntarily stop eating and drinking because they are ready to die, believing that continuing to live is pointless, and want to control the manner of death. The deontological arguments address the principles of autonomy, nonmaleficence, beneficence, and justice. Autonomy or self-determination of a competent patient dictates that he/she has the right to accept, refuse, or stop any medical interventions. Healthcare providers have the duty and responsibility to honor their patients' choices if they wish to stop nutrition and hydration to hasten death. However, these patients should be assessed by skilled clinicians for their underlying physical and psychosocial reasons and their decision-making abilities.

Nurses provide the majority of day-to-day care to their patients, and they have a unique responsibility to provide a caring response to their patients' needs. Nurses often are the ones who provide extensive emotional support to their patients and the families. Patients and families facing end-of-life issues especially need nurses' guidance and emotional support. Nurses can help them search for the information and support the choices they make about how they want to finish their journey in this world.

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Appendix A

Patient Follow-up Visit

Legacy Physician's Group

Patient: Thomas Keller

DOB: 10/15/1925

DOV: 8/21/2010

History of Present Illness: Mr. Keller is an 84 year old white male living in this facility since 2008 after suffering from frequent falls, increasing weakness, and being unable to take care of himself. He had left side ischemic stroke on 4/27/10 with right sided weakness and dysphagia. He has been refusing recommended pureed diet with nectar thick liquids and signed a waiver for regular diet with thin liquids. He was hospitalized in June and July of this year for aspiration pneumonia and CHF exacerbation. He has a PEG tube which was inserted during the last hospitalization and is on nightly one-can bolus feeding as he consented. Within the last several weeks, Mr. K started to refuse to take oral food and drink. He was seen by the geriatric psychologist and geriatric psychiatrist and was put on a trial of Zoloft, an antidepressant. Starting last week, Mr. K refused nightly one-can bolus feeding. He has been verbalizing his wishes to the nursing staff that he wants to die and be with his wife. He has lost more than 20 pounds within the last four weeks. His two daughters called to see him and insisted the frequency and the amount of bolus feedings be increased.

Past Medical History: congested heart failure, coronary heart disease, Hypertension, Hyperlipidemia, Osteoarthritis, Gastric Reflux disease, multiple falls, stroke on 4/27/2010

Past Surgical History: right total knee replacement in 2005, Coronary artery bypass surgery in 2004

Current Medications: Plavix, ASA, Lisinopril, Metoprolol, Coreg, Megace, Zoloft, Prilosec, Lipitor, Multivitamin, Tylenol, Norco 10/325, laxatives of choice

Allergies: NKDA

Social History: Mr. K is a retired History professor. He became widowed after 54 years of marriage. His wife died from ovarian cancer in 2006. He has two daughters- one lives in Plano, and the other lives in South Dallas. He denies alcohol drinking, smoking or using any illicit drugs. He also denies previous history of depression. He is a Christian and attended a local Baptist Church near his home before moving into this nursing facility. He loves to read, sing hymns, play piano and travel.

Family History: Mr. K denies family history of cancer, heart diseases or any psychiatric problems. He has one younger brother, who lives in Michigan.

Review of Systems. This is actually his physical exam (objective data): Mr. K was resting comfortably in bed during the visit. He appears emaciated and weak. He is alert and oriented to his name, place, and time. He is pleasant and cooperative. He answers all the questions appropriately. He verbalizes his wishes again during the visit, "Enough is enough. Please let me go. I have better life in another world with my wife. I had a good life in this world, and I am very satisfied. Now it's time for me to go". He has no distress. He denies pain. HEENT: normocephalic. Lips, gums, and oral mucous membrane are dry. Neck: supple, no lymphadenopathy. Lungs: shallow and unlabored respirations, no abnormal sounds. CV: 2+ pitting edema bilateral lower extremities. Regular heart rate. Abdomen: flat, soft, non-tender. PEG tube intact. No drainage or s/s infection noted. SKIN: pale gray color, poor skin turgor. Sacral area redness, no skin break down noted. Neuro: alert and oriented to name, place, and time. Cranial nerves II-XII intact.

Physical Exam: VS: Temp 97.6, BP 94/56, HR 84, RR 17, Ht 5'6", WT 137 lbs (on admission 5/2008), 135 lbs in 4/2010, 130 lbs in 6/2010, 122lbs on 7/22/2010, 98lbs on 8/20/2010

LAB: 8/20/2010: Na 147, K 4.2, Albumin 1.7 g/dl, Prealbumin 5.6 mg/dl, WBC 5.6, Hgb 13.6, HCT 39.8. UA/C&S done on 8/19: negative for UTI

Impression: Mr. K has severe hypoalbuminemia secondary to refuse nutrition and hydration. He does not seem to be depressed. He simply wants to die because he is tired of this kind of life. He is no longer the same man again, and he feels that it is time for him to meet his wife in another world.

Plan:

1. Will conduct a care plan meeting as soon as possible with the patient, his families, the director of nursing, social worker, his primary care providers, and the facility administrator.
2. Will discuss the process and consequence of voluntarily stopping nutrition and hydration. Make sure that both the patient and his families are well informed and understand the process.
3. Will consult hospice care if the patient and his family agree.

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Description of ethical conflict:

The ethical conflict arises from this case study is: Should Mr. K be allowed to voluntarily refuse nutrition and hydration to hasten death? Or should he be given increased amount and frequency of tubing feeding via his PEG as requested by his family?

Resolution of the ethical conflict:

We conducted a care plan meeting on 8/24 with Mr. K, his two daughters, director of nursing, administration, his primary care providers, social worker, geriatric psychologist, and geriatric psychiatrist. Mr. K verbalized his wishes again that he would not eat or drink, or continue the tube feeding. He wanted to die. However, his daughters kept saying, "Dad, you need to eat or let them increase your tube feedings". We explained to the daughters that it was their father's wish, and he had the advance directive for not prolonging his life. His wishes should be honored. However, the two daughters refused. They became very upset, and we could not proceed with the meeting.

The second care plan meeting was conducted on 8/30. Mr. K, his daughters, his son-in-laws, several of his grandchildren, his primary care providers, director of nursing, social worker, and the facility administrator attended the meeting. Mr. K again stated once again that he felt it was pointless for him to live like that. He was ready to go. He would not continue to have any nutrition or hydration no matter what his families said. Finally, his daughters agreed to honor his wishes and stopped the nutrition and hydration.

Hospice care was consulted with the permission of the patient and his families. All the nutrition and hydration stopped once hospice care starts the service. Mr. K died peacefully on the 11th day after all the nutrition and hydration were discontinued.

Appendix B

Case Consultation Worksheets

Worksheet A

Step1: Personal Responses

In general, I am opposed to encouraging patients with terminal illness or with irreversible health conditions to voluntarily refuse nutrition and hydration to hasten death, especially with younger patients. However, I believe that every case is different. If the patients are very old and have many medical problems, such as terminal illness or irreversible health conditions, and they want to voluntarily stop nutrition and hydration to hasten death, I think their wishes should be honored.

Step2: Facts of the case

a. Mr. K is 84 years old with multiple medical problems, such as CHF and stroke.
b. He was a very active person, but now he is wheelchair bound-poor quality of life.
c. He is always against a PEG tube, but he agreed to have PEG tube placed to please his family- against his wish.
d. Mr. K is mentally competent to make any decisions in regard to his medical interventions.
e. Mr. K is not depressed although the geriatric psychiatrist prescribed a trial of antidepressant-Zoloft- It did not work.
f. Mr. K refuses to have nutrition and hydration, but his daughters insisted that tube feeding amount and frequency be increased.
g. Mr. K's daughters are distressed and need more information on voluntarily stopping nutrition and hydration and need emotional support.

Step 3a. Clinical/Psychological Issues Influencing Decision

a. Is Mr. K depressed? Is he having any pain or discomfort? Is he having any treatable infection such as UTI?
b. Family distress- What does suffering mean to this patient/family? Are the family members afraid that voluntarily refusing nutrition and hydration will make the patient suffer? What is the support system? Are there any financial concerns?

Step 3b: Initial Plan

a. Consult geriatric psychologist and geriatric psychiatrist to assess if the patient is depressed.
b. Review the most recent CBC, UA/C&S, CMP (was done on 8/19 and 8/20).

c. Spend time and communicate with the patient to find out what makes him to make such decision.
d. Provide alternate options for end-of-life care, such as hospice to both the patient and his family.
e. Conduct a care plan meeting with the patient, his family members, director of nursing, social worker, his primary care providers, and the facility administrator.
f. Provide emotional support to both the patient and his family.
g. Be available to both the patient and his family to answer any questions.

Step 4: Policies & Ethical Code Directive

ANA Code of Ethics for Nurses and facility policies in regard to voluntarily refusing nutrition and hydration

Step 5: Ethical Principles analysis

a. Autonomy- respects the patient's choice in regard to his medical interventions and honors his wishes.
b. Beneficence- doing of good. Some available Ethical and Medical literature stated that decreased nutritional intake increases the production of endorphins, and dehydration leads to an increase in dydorphin levels, thus lead to increased comfort levels in patients. Also need to meet with all stakeholders to discuss what is the best interest for Mr. K. Since Mr. K is mentally competent, and he has advance directive, he is the one who makes the decision.
c. Nonmaleficence- prevents harm. Provide palliative care such as hospice to provide comfort care to the patient and provide emotional support for the family.

Step 6: Possible Legal Issues

a. Right to die case law review
b. Advance directive
c. Provide thorough information and make sure the patient and his family are well informed and understand the process.
d. Distinguish between voluntarily stopping nutrition and hydration and physician-assisted suicide and euthanasia.
e. Failure to teat issues and inadequate pain relief.

Appendix C

Case Consultation-Worksheet B

Plan & Implementation Strategy

a. Review the most recent CBC, UA/C&S, CMP (was done on 8/19 and 8/20) - no UTI, severe hypoalbuminemia secondary to decrease nutritional intake.
b. Consult geriatric psychologist and geriatric psychiatrist to assess if the patient is depressed- a trial of antidepressant is initiated.
c. Spend time and communicate with the patient to find out what makes him to make such decision- poor quality of life, life is pointless, ready to die.
d. Had care plan meeting with the patient, his family, the patient's primary care providers, social worker, geriatric psychologist, geriatric psychiatrist, the director of nursing, and the facility administrator- the patient verbalized his wishes of discontinuing his nutrition and hydration and die. Family members became very agitated, and the care plan meeting could not be continued.
e. Second care plan meeting with the patient, his daughters and son-in-laws, and several of his grandchildren, his primary care providers, social worker, director of nursing, and the facility administrator-his family members agreed to honor his wishes by stopping all the nutrition and hydration.
f. Hospice care was consulted on the same day, and all the nutrition and hydration was discontinued as soon as hospice service started.
g. Provide emotional support to both the patient and his family- patient advocate
h. Be available to both the patient and his family to answer any questions.

Write down how your plan:

Advances Clinical/Psychosocial Interests:

I reviewed his most labs (done on 8/19 and 8/20/2010), such as CBC, CMP, UA/C&S. This patient did not have any treatable infections. He was not anemic. He did have severe hypoalbuminemia secondary to the decreased nutritional intake, which he had been refusing for the last several weeks. He was not depressed. He verbalized that he had a good life and was ready to meet with his wife in another world. I spent a lot of time with him and his family and provide emotionally support. I also provide information about hospice care to the patient and his family. I made myself available for them if they had any questions and concerns.

Adheres to agency policies and professional ethics code:

a. This nursing facility does not have specific policies in regard to allowing voluntarily refusing nutrition and hydration in the competent, well informed residents.
b. I incorporated ANA Code of Ethics for Nurses into my decision-making process.

Minimizes harm and maximizes other ethical principles to the extent possible for the client and relevant others:

a. Autonomy- decisions made by this competent, well informed patient was respected
b. Beneficence- hospice care was consulted before the patient stopped all his nutrition and hydration to provide end-of-life to the patient and emotional support to both the patient and his family
c. Nonmaleficence- hospice care was consulted to provide end-of-life care to the patient and emotional support to both the patient and his family. This patient was informed well that if he decided to change his mind to continue to have nutrition and hydration, he could do it any time.

Allows you to operate within the law:

Voluntarily stopping nutrition and hydration in competent, well informed patients is legal in the United States. There is also a growing ethical and moral consensus on this issue too.