88 year-old Mr. Z from a nursing home is admitted by ambulance to the emergency department with respiratory failure, and an elevated temperature. He has shallow ventilations 50 times a minute and has been placed on Oxygen. The emergency physician intubates Mr. Z and his ventilation parameters improve. Subsequently, a chest X-ray shows left lower pneumonia and an elevated white blood cell count. A large amount of secretions are suctioned out. After some sedation, Mr. Z is resting and ventilating quietly. His vital signs are stable. The patient carries a convincing diagnosis of dementia. His family says he was competent when he signed a living will five years previously but has since progressed to the point where he is bedridden, fed by staff, unable to discern place and time but seems to brighten around his family. He has not offered any meaningful verbal dialog for one year. When he is questioned, she offers disjointed answers, or looks out the window wistfully.

In the emergency department, Mr. Z is sedated for intubation and is non-verbal. He grimaces to painful stimuli, does not open his eyes spontaneously and does not follow simple commands. At this point, the faxed records arrive and the first page is a 'Living Will' declaration, signed and notarized in 1995 by the patient, in which he states the following:

"I xxxx being of sound mind, willfully and voluntarily make this declaration to be followed if I become incompetent. This declaration reflects my firm and settled commitment to refuse life-sustaining treatment under the circumstances below. I direct my physician to withhold or withdraw life support that serves only to prolong the process of me dying if I should be in a terminal condition or a state of permanent unconsciousness. I direct that treatment be limited to measures to keep me comfortable and relieve pain, including pain that might occur by withholding or withdrawing life sustaining treatment. In addition, if I am in the condition described above, I feel especially strong about the following forms of treatment: I do **not** want cardiac resuscitation, blood or blood products, tube feeding or any other form of hydration or nutrition, intubation and/or mechanical respiration, dialysis, antibiotics, any form of surgery or invasive diagnostic test. In addition, I do **not** want to designate another person as my surrogate to make medical treatment decisions for me if I should become incompetent."

Two blood relatives (daughters) arrive shortly after, and both issue orders

First relative: "The living will is very clear. I want him extubated immediately and made comfortable with morphine until he dies."

Second relative: "Wait a minute now. On admission to the emergency department, he did meet the criteria for the living will and his wishes should have been followed. But now, since he has been intubated and put on mechanical ventilation, my father is very stable and no longer 'terminally ill'. There is no overriding reason why he cannot be extubated in a day or two and go back to square one. He now has the strong potential to improve (on antibiotic and supportive care) that he did not have before the living will was ignored. Intubation changed all that. Mechanical ventilation is not prolonging death, it is bridging an unstable process so that he may anticipate life. Therefore I say that the living will is no longer relevant. The act of placing my father on life support supersedes the terms of the living will and we are now in a mode to support him if the odds are such that he has a better chance of life than death."

How do you handle this?

1. What accounts for the different interpretations of each daughter?
2. Can “terminally ill” have different definitions at different moments?
3. Can we assume what the father would want in this situation given the living will was signed five years ago, prior to this moment?
4. Should the care team extubate Mr. Z right now?