Long-Term Feeding Tubes: Ethical Issues in Physicians' Decision Making*

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The North Carolina Medical Society (NCMS) recently adopted a position statement on the placement of long-term feeding tubes. Its purpose is to provide ethical guidance to physicians in light of the current medical literature. The position statement was developed initially by a subcommittee of the NCMS Ethical and Judicial Affairs Committee. The subcommittee's report was reviewed by representatives from North Carolina hospitals, medical directors of nursing homes, hospice, home health, speech pathology and elder law, prior to being adopted by the Board of Directors of the NCMS.

Why did the NCMS adopt a position statement on long-term feeding tubes? What ethical issues are presented by the decision whether or not to place a long-term feeding tube?

The following clinical scenario framed the subcommittee's inquiry: *An incompetent adult patient who suffers from a chronic, progressive illness develops swallowing difficulty. His prognosis is such that, to a high degree of medical certainty, he will not regain ability to take food by mouth. Will feeding tube placement offer clear medical benefits? Will it prolong the patient's life, prevent malnutrition and aspiration? Will it promote the patient's dignity? Will it make the patient more comfortable?*

Since long-term feeding tubes have been placed with increasing frequency in recent years, the subcommittee inferred that physicians, families, nurses and other care providers must be answering these questions in the affirmative. Unfortunately, the medical literature is to the contrary. The statement that follows can also be found on the NCMS Web site: *http://www.ncmedsoc.org/non_members/longterm_feedingtube_physician.pdf.*

• Feeding tube placement is associated with an in-hospital mortality of 15-25 percent, and a one-year mortality of 60 percent.

• Co-factors associated with increased risk of mortality include: advanced age, CNS pathology (CVA, advanced dementia), cancer (except early stage Head/Neck cancer), disorientation and low albumin.

• Aspiration occurs in up to 50 percent of patients being tube fed.

• For patients with advanced dementia, feeding tubes have not proven effective in prolonging life, in preventing aspiration or even in providing adequate nourishment.[1]

Palliative care specialist, David Weissman, MD, has outlined the ***tube feeding death spiral:*** [2]

1. Hospital admission for complications secondary to brain failure or other predictable end organ failure due to primary illnesses (e.g. Urosepsis in the setting of advanced dementia)
2. Inability to swallow documented and/or direct evidence of aspiration and/or weight loss associated with low or no p-o intake
3. Swallowing evaluation followed by a recommendation for non-oral feeding
4. Feeding tube placed followed by increasing patient agitation, resulting in feeding tube dislodgement
5. Re-insertion of feeding tube; restraints placed
6. Aspiration pneumonia
7. Intravenous antibiotics and pulse oximetry
8. Repeat steps 4-6 two or more times
9. Family conference
10. Death

• The specter of aggressive, over-treatment was a major factor motivating the patients' rights movement.

• Legal and ethical standards have been developed to support an informed decision to withhold or withdraw any medical intervention, including tube-feeding.[3]

• North Carolina does not prejudice with unique restrictions the medical decision whether or not to place a feeding tube.

• There is no ethical or legal warrant for the physician to evaluate differently a decision to withdraw tube-feeding from a decision to withhold tube-feeding.[4]

• Advance care directives, such as living wills, health-care powers of attorney, etc., enable decisionally-capable patients to anticipate and plan for the contingency of losing their ability to communicate health-care decisions, including a decision whether to withhold or withdraw tube-feeding.

• Persons authorized to give informed consent to feeding-tube placement on a patient's behalf may also make an ***informed refusal*** of tube placement.

• In the absence of advance care directives, a surrogate's decisions regarding feeding tube placement or removal should be based, whenever possible, on what the patient would choose in the circumstances. Otherwise, the surrogate's decisions should be guided by considering the patient's best interests.

The physician should not bias a discussion of the pros and cons of tube feeding with an implicit assumption that nursing home residents would prefer tube-feeding in the event they cannot swallow. On the contrary:

• A study of 421 randomly selected, competent persons living in 49 nursing homes found that only one third would favor feeding tube placement if they were unable to eat because of permanent brain damage. 61 percent opposed tube-feeding. Of those who initially favored tube placement, 25 percent changed their preference when they learned that physical restraints might be necessary to facilitate feeding tube use.[5]

• The desire for tube feeding decreases as the hypothetical degree of cognitive impairment increases.[6]

Tube feeding does not necessarily provide medical benefit to a dying patient by enhancing quality of life nor by reducing suffering.

• Tube feeding is associated with increased agitation and may reduce

quality of life and dignity because it increases the need for physical restraints;[7]

• Typically, dying patients do not experience hunger or thirst;

• Malnutrition, a concomitant of the natural dying process, should not be confused with "starvation";

• While dry mouth commonly occurs in dying patients, tube-feeding does not relieve it;

• Complete relief from symptoms associated with dry mouth may be achieved with ice chips, moist sponge, sips of liquid, lip moisteners, hard candy and mouth care."[8]

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Recommendations:

• Prior to feeding-tube placement in a decisionally incapable patient, it is the physician's ethical responsibility to determine whether the patient has executed an advance directive whose provisions may apply to the placement decision. Otherwise, the physician should take the lead in discussing with the patient's surrogate decision maker the pros and cons of long-term tube feeding.

• The physician should be prepared to address the common tendency to confuse "malnutrition" (a concomitant of the natural dying process) and "starvation."

• The physician should relate decisions about tube feeding +/- to achievable goals of care. A summary of discussions regarding tube-feeding should be documented in the medical record.

• The goals of care should be reviewed regularly to determine whether or to what degree tube-feeding, promotes or contradicts them.

• Consultation with Hospice or with a Palliative Care Service facilitates setting realistic goals of care.

• Since tube-feeding has not proven beneficial in patients with advanced dementia, but on the contrary, is associated with significant increased morbidity, mortality and indignity, physicians may, in good conscience, recommend that it be withheld or withdrawn in these circumstances.

• In the event a valid decision is made to forego tube-feeding, the physician should enter in the patient's medical record an order "Do Not Tube Feed."

• Patients who are genuinely hungry should be allowed to eat anything they please.

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* This document was written with adult patients in mind; issues facing pediatric patients were not discussed by the authors and are not addressed herein.

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