

# Artificial Nutrition in the Palliative Care Setting: What's the Patient's Goal?

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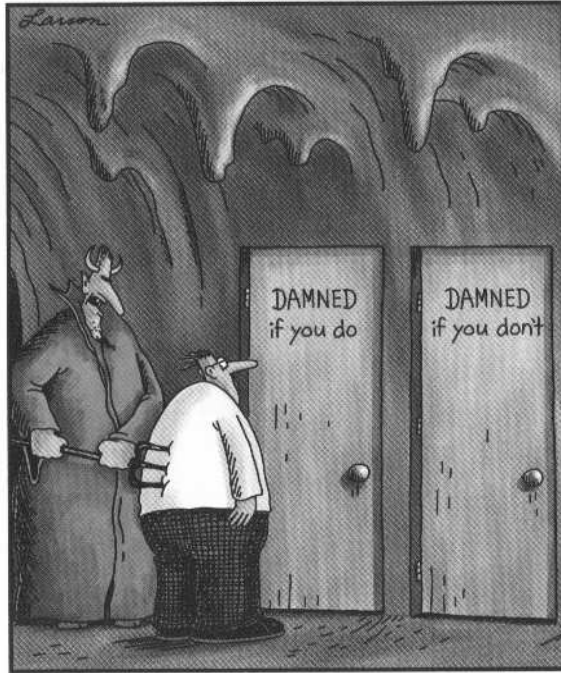
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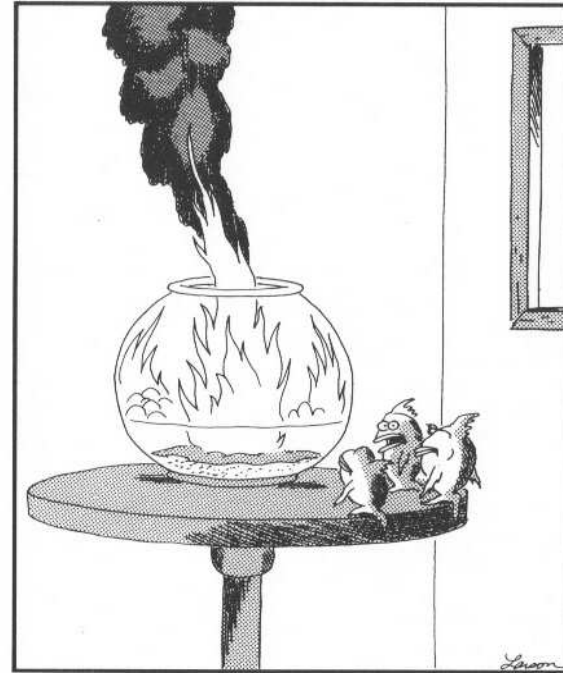


# Learning Goals

- Identify the proven benefits of artificial nutrition.
- Identify the burdens of artificial nutrition.
- Describe the ethical principles that guide treatment decisions.
- Describe the skills needed for a compassionate and competent conversations with the patient and family members.



"C'mon, c'mon—it's either one or the other."



"Well, thank God we all made it out in time. ...  
'Course, now we're equally screwed."

# Definitions

## ■ Non-Oral Feeding

- provision of food by NG, G-tube, or G-J tube or by TPN.

## ■ Artificial Hydration

- provision of water and electrolytes by any non-oral route - -
- IV, NG/G/GJ tube or SC (hypodermoclysis).

# Patients who Benefit from ANH


- Post CVA or other neurological illnesses
  - ALS, Parkinson's
- Reversible disease processes
- Trauma patients
- Gastric outlet or bowel obstructions
- Chronic Neurogenic Colon
  - Need > 4 wks of nut. support
  - Significant dysphagia
  - High likelihood of recovery

# Benefits of ANH

- Within the proper contexts:
  - Reversible disease process or complication
    - Bowel obstructions, acute trauma, stroke with good prognosis
  - Chronic Neurological Illnesses
    - ALS, Parkinson's
  - Advanced Cancers with bowel obstructions
- ANH can relieve the obstruction and/or supply appropriate nutrition for healing and a recovery



# Unproven Benefits of ANH in Patients with E/S Diseases

- Reduction in aspiration pneumonia
  - Reduction in patient hunger or thirst
  - Reduction in patient suffering
  - Reduction in infections or skin breakdown
  - Improved survival duration
- 

# Burdens of ANH

- Risk of aspiration pneumonia is the same or greater than without oral feeding
- Increased need to use physical restraints
- Wound infections
- Abdominal pain and tube related discomfort
- Costs
- Indignity







# Progressive or Incurable Medical Conditions

- Progressive disease that no longer responds to life prolonging treatments –
  - Heart failure or COPD refractory to all meds
  - Metastatic Cancer that is growing despite chemo or rad tx
  - Chronic aspiration pneumonia in the setting of very advanced dementia



# Progressive or Incurable Medical Conditions

- Progressive Decline in functional abilities
  - Increasing need for medical attention with little improvement in functional ADL's
  - Increasing frequency of ED visits, ICU admits, etc
  - Progressive and steady weight loss
- Psychological Acceptance of Dying Process
  - Major depression is excluded
  - Patient is personally starting the grieving process




# Syndrome of Imminent Death

- Final Common Pathway

- Except sudden deaths

- Early Stage:

- bed bound
  - loss of interest and ability to eat/drink
  - cognitive changes – hypo or hyperactive delirium or sedation
- 



# Syndrome of Imminent Death

## ■ Mid Stage:

- further decline in mental status: obtunded
- pooling of oral secretions, “death rattle”
- fever is common

## ■ Late Stage:

- coma
- cool extremities
- altered resp pattern
- fever is common

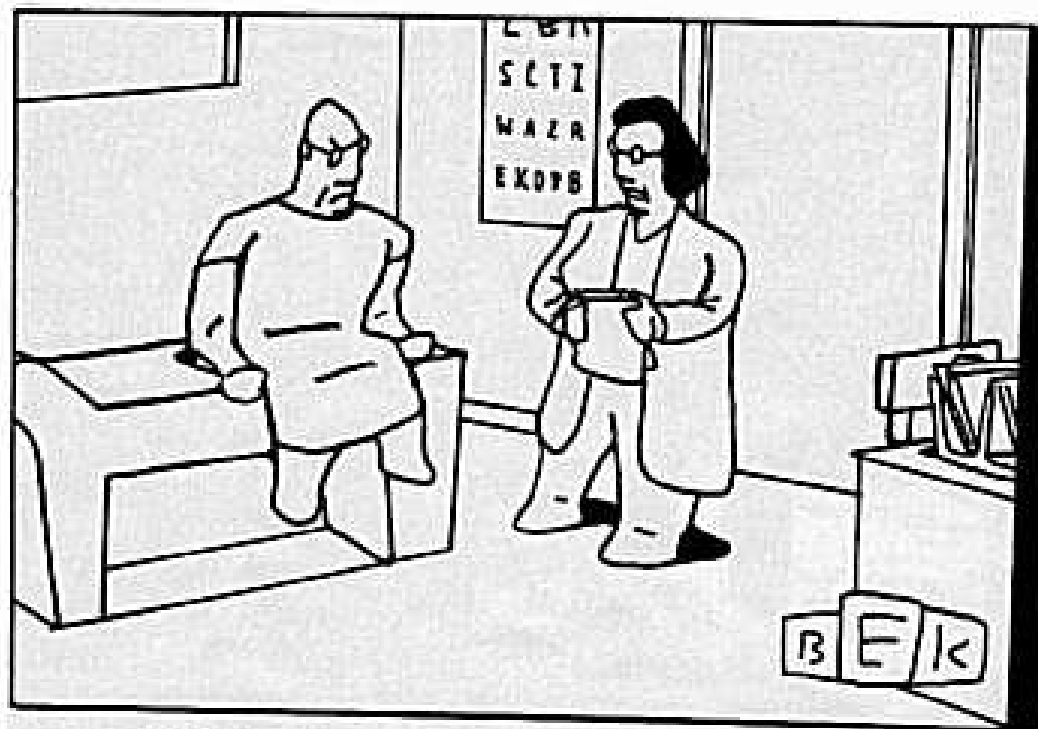
## ■ Time Course – hours to days to 2-3 weeks

# The “Supanich Triad”

- Dying patient with a feeding tube, restraints and pulse oximetry.
- Tube Feeding Death Spiral Scenarios
  - Admit with complication of known adv chronic illness
  - Inability to swallow, +/- aspiration, +/- wt. loss, minimal p.o. intake
  - Swallow eval with rec for non-oral feedings
  - PEG placed, patient is agitated, PEG is “removed” or “dislodges”
  - Order for reinsertion ...

# The “Supanich” Triad

- Hand restraints ordered
- Aspiration Pneumonia
- IV antibiotics and pulse ox ordered
- Repeat previous 4 steps at least twice
- Palliative Care consult ordered for family conference
- Death of patient



*"Would you describe the pain everyone else causes you as dull and throbbing or sharp like a knife?"*



# Ethical Conversations

- Patient Autonomy and Informed Consent for PEG placement
  - Recent study of 154 consecutive PEG placements, only one chart had written documentation of a procedure specific discussion of benefits and burdens of and alternatives to placement of PEG.

- Brett AS, Rosenberg JC. The adequacy of informed consent for placement of G-tubes. Arch Intern Med 2001; 161:745-8.

# Ethical Conversations

## ■ The placement of a PEG should

- benefit the patient overall – relieve blockage, provide nutrition source the body can utilize for healing and recovery
- should not result in net harm to the patient and benefits should outweigh harms or risks





# Ethical Conversations

- There is no medical, ethical or legal mandate to provide ANH to actively dying patients
  - When risks outweigh benefits
  - When patients tell us they are not hungry or thirsty
- ANH is a medical treatment like hemodialysis, mechanical ventilation, antibiotics, etc
- Care that assures the patient's human dignity should never be stopped – bathing, oral care, skin care, clean clothes and bedding, a safe, comfortable environment, respect for religious or spiritual practices, etc.



# Ethical Conversations

- Patients have a right to refuse treatments or asked that they be stopped
  - Articulate choice in written A.D., like 5 Wishes or Maryland Directive AND discuss with chosen surrogate.
  - Ethically and legally, there is **NO DIFFERENCE** in withdrawing or withholding treatments that are nonbeneficial or ones that a patient with capacity to make decisions refuses.



# Ethical Conversations

- Syndrome of Imminent Death (SID) Patients
- Withholding or withdrawing ANH is NOT
  - Euthanasia
  - Assisted suicide
  - Physician-assisted death

# Ethical Conversations

- Current Catholic Ethics
- 2004 Papal Allocution and Sept, 2007 Comments from Cong for the Doctrine of the Faith
  - Specific to PVS patients
  - Still uses benefit and burden approach – if its use causes harm to the patient or can no longer be assimilated or patient is imminently dying – no moral obligation to provide it.





# Cultural Values

- Act of eating or feeding the sick can be a symbol of caring and providing nurture and hope.
  - Can appear contrary to “normal” societal values
  - Can be equated by family to “starvation”, “euthanasia” or “murder”
- Most religions recognize that death is a part of life and that ANH can be withdrawn or withheld when the risks or burdens outweigh benefits.





# Physician/Nurse Cultural Values

- Physicians and nurses tend to understand that ANH treatments are like other medical treatments or procedures.
  - Discuss benefits and burdens
  - No benefit in patients with chronic progressive incurable illnesses and those imminently dying



# Dietitian Cultural Values

- Agreed to withhold or withdraw if in A.D. or surrogate communicated choice of patient
- “When in doubt, feed” ...
- ANH as feeding to provide nutrients and fluids to at least maintain weight, muscle mass, and hydration.

Enrione E, Chutkan S. Preferences of registered dietitians and nurses recommending artificial nutrition and hydration for elderly patients. *Jl of Am Diet Assoc.* 2007;107: 416-421.



# Alternatives to ANH

- Hand-feeding with thickened foods
- Small sips or tastes of favorite foods
- Keep mouth moist
- REMEMBER - - DYING PATIENTS ARE KETOTIC –  
Have little or no appetite
- AND – NO evidence that AH relieves thirst
- Use of aggressive comfort measures: pain and sx management, freq turn, freq mouth care, family support



# Discussions with Families

- Approach that minimizes guilt within families or upon any particular family member
- Review patient's current dx, prognosis and review the signs of imminent death
- If patient has made explicit choice in A.D., family doesn't need to make a decision...
- Have the family share the values that were important to the patient and how the patient lived those values.



# Discussions With Families

- “What would your (family member) tell us she/he would want if they could speak with us now?”
- Let them know that the dying person does not feel hunger (ketosis) and that it is often painful to have food in the gut due to ↓ blood supply.
- Let them know that they can offer sips or tastes of food to their loved one.
- Offer them a time frame in which to discuss with other family or spiritual counselors.
- Provide booklet “Hard Choices for Loving People”

# Family Discussions

- If the family decides for ANH - -
  - Establish a timeframe – 4-8 weeks
  - Establish treatment goals to be accomplished
  - Re-evaluate within the timeframe to see if goals accomplished – wt gain, improved overall function
- Decides to stop ANH or not start
  - Hand feeding if pt aware and alert
  - Maximal comfort measures, death within 14 days



# Family Discussions

## ■ Suggested comments:

- From what you have shared already, I can see that you are a very loving (daughter/son) and I know you want to do the loving thing for your \_\_\_\_.
- *Your (relative) is now dying from their (terminal illness) and one of the major signs to us is that they voluntarily decrease the amount they eat.*
- *Remember, they are dying from the disease, they are not starving.*
- *I want to assure you that we will do everything we can to assure their comfort, along with what you are doing to comfort them.*
- *Now that their physical body is declining, they are focusing their attention on spiritual issues/matters.*



# Summary

- Defined ANH
  - Discussed benefits and burdens of ANH
  - Discussed Syndrome of Imminent Death
  - Discussed the “Supanich Triad”
  - Discussed ethical conversation points
  - Discussed family conversation points
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