

Promoting Human Dignity Through Tube Feeding: Finding the Mean*

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As those who are integrally involved in the delivery of end-of-life care know far better than I do, there comes a point when the task of medicine becomes primarily, if not solely, to care because it can no longer cure. Perhaps one of the most important virtues for those who provide care for those living with a life-threatening illness or injury is the ability to know when this moment has arrived — not an instant premature, but not so late that the dying person endures additional suffering.

This virtue is the capacity for a truly prudential moral judgment regarding the use of life-sustaining technology within the Catholic moral framework. *The Ethical and Religious Directives for Catholic Health Care Services*, 4th ed. (directives) articulate the basis for such judgments in the following manner:

The use of life-sustaining technology is judged in light of the Christian meaning of life, suffering and death. Only in this way are two extremes avoided: on the one hand, an insistence on useless or burdensome technology even when a patient may legitimately forgo it and, on the other hand, the withdrawal of technology with the intention of causing death. (Part Five, Intro.).

While the explicit focus of this passage pertains to the use of life-sustaining technology, I would submit that the real concern is actually more about respecting the human dignity of those near the end of life than it is about the use of technology itself. In this sense, the directives are articulating that old Aristotelian (and Thomistic) theory of virtue as the mean between two extremes, applied specifically to the question of how best to respect human dignity at that point in a person's life when he or she is most vulnerable.

In the remainder of this essay I will attempt to illustrate the significance of avoiding such extremes, by considering the

example of “tube feeding,” or medically assisted nutrition and hydration, through the lens of the directives, particularly No. 58.

Considering Directive No. 58

Contrary to popular opinion, or what I can only surmise is popular opinion based on my own experience as an ethicist working in Catholic health care, Directive No. 58 is not primarily about “tube feeding.” Rather, the directive is primarily about providing “nutrition and hydration to all patients, including patients who require medically assisted nutrition and hydration. . . .” The very fact that the subject of this directive is the provision of “nutrition and hydration” and that the object is “all patients” tells us that the predominant concern is *not* about “tube feeding” *per se*, but about the benefit that tube feeding provides by satisfying basic physiologic needs (when in fact it does so). Indeed, “medically assisted” nutrition and hydration is mentioned only as a qualifier. Yet, this directive recognizes that the value of satisfying such basic needs can be counterbalanced by burdens associated with medical assistance, where the directive says, “so long as this is of sufficient benefit to outweigh the burdens involved to the patient.”

Implicit in this directive are a number of presuppositions worth noting. First, the satisfaction of the physiologic need for nutrition and hydration is always a benefit. In other words, one cannot — consistent with the Catholic moral tradition — say that satisfying this need is *never* a benefit or of no benefit whatsoever. Yet, this directive also presupposes that there may be times when “tube feeding” is medically contraindicated, either because the body can no longer assimilate it or because excessive clinical burdens may be associated with the tube. Accordingly, it is not *always* and necessarily the case that the benefit is sufficient to warrant its provision. In this way, Directive No. 58 leads us away from the two extremes of “never” and “always” and guides

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us toward that virtuous mean through which human dignity can best be served.

Also, implicit in this directive is the presupposition that there may be means other than tube feeding for providing nutrition and hydration. In many circumstances, hand feeding may be a scientifically sound option for patients who are unable to feed themselves but are still able to take at least some nutrition and hydration orally. One of the downsides of tube feeding is that it reduces the interpersonal and social dimensions of the interaction between staff doing the feeding and vulnerable patients receiving the nutrition and hydration. A significant advantage of hand feeding with respect to promoting human dignity is that it can accomplish the same physiologic goal, while fostering a more intimate and caring relationship — a human connection — between the person doing the hand feeding and the patient.¹ While tube feeding is often the most efficient way to provide the daily caloric intake needed to sustain life, hand feeding provides the companionship needed to sustain the human spirit and is more affirmative of the unique and incomparable worth of every human life.

Yet, tube feeding is often the preferred choice, even when oral feeding is physiologically possible, for several reasons. For example, there may be state and/or institutional regulations regarding daily nutritional intake; limitations regarding surrogate authority to discontinue medically assisted nutrition and hydration; a limited number of staff or volunteers to do hand feeding; and, in some states, greater reimbursement rates for nursing homes that care for tube-fed rather than hand-fed residents.² Of course, many patients are physically unable to take nutrition and hydration orally. In such cases, a decision to initiate or continue tube feeding must take account of the indications for its use, the expected benefits, and the risks, complications and burdens.

Basic Clinical Considerations

Without going too deeply into the clinical details (and thus way beyond my area of expertise), there are some important considerations that patients, families, surrogates, ethicists and staff need to keep in mind to ensure that the use of feeding tubes promotes human dignity. One such consideration is the type of tube feeding that will be used. Different types of tube feeding have distinct purposes and require dif-

ferent formulas for feeding; and some types are appropriate only for temporary use as a bridge therapy, while others are intended to be used permanently. For example, nasogastric and nasointestinal tube feeding is intended only for short-term use because of discomfort and the risk of sinus blockage, infection and ulceration.

Long-term or permanent feeding requires a percutaneous endoscopic gastrostomy tube (a PEG tube) that is placed surgically or laparoscopically, or the surgical placement of a jejunostomy tube (J-tube).³ While these methods are more appropriate for long-term feeding because they deliver the nutrition and hydration directly to the stomach or intestinal tract, they too carry the real risk of clinical complications. Such complications may include surgical site irritation, leaking or infection; diarrhea; nausea; vomiting; metabolic derangement; edema; aspiration pneumonia; lung congestion or swelling of the brain.⁴ The rates of complications associated with long-term PEG and J-tubes range from 32 percent to 70 percent.⁵

It is, of course, equally necessary to take into account the indications for tube feeding, the expected benefits and the outcomes. The use of a feeding tube is appropriate for a wide variety of indications, including when a person has an esophageal obstruction, such as from head or neck cancer; an obstruction in the upper intestinal tract; difficulty swallowing due to a neurologic impairment resulting from stroke, coma, or a persistent vegetative state; or inadequate nutritional intake due to dementia, severe illness or short bowel syndrome. The expected benefits of tube feeding include better nutrition, improved skin integrity, increased comfort and less pain, satiation of hunger or thirst, improved quality of life, decreased risk of aspiration-related pneumonia, and prolonged life.⁶

However, some studies show that the expectations of surrogates and families are much greater than the actual outcomes related to these benefits, and that the incidence of aspiration-related pneumonia, decubiti and functional status are similar three months prior to the time tube feeding is initiated as they are three months after.⁷ Moreover, certain patient populations, such as those with advanced dementia, end-stage cancer or certain metabolic disorders, or patients who naturally lose their appetite and thirst because they are actively dying, may not experience some or any of these

benefits. Yet, the rate of feeding tubes in these patient populations remains high, partly due to the significance that families and care providers attribute to tube feeding as a symbol of their love and care.⁸

Conclusion

A beginning assumption underlying this essay has been that moral medicine is good medicine, and good medicine is moral medicine. Essentially, what this means is that if medical care is to respect and promote human dignity, it must at a bare minimum be clinically sound. Accordingly, we need to remind ourselves from time to time of the possibility that a benevolent but misplaced emphasis on the symbol of our love might, in the particular case, actually interfere with respecting and promoting the dignity of those we love through the provision of clinically appropriate care. Decision-making around the use of feeding tubes must take into account the clinical context of the circumstances in which, and the purpose for which, it is being used. Such decision-making should aim for that virtuous mean through which human dignity is best served: by providing care that avoids an insistence on useless or burdensome means of maintaining life and also avoids the withdrawal of such means with the intention of causing death (cf. Directives, Part Five, Intro.).

As a final note, one might observe that this essay has scantily mentioned the issue of tube feeding for patients in a persistent vegetative state. While this is an issue of tremendous significance insofar as it concerns how some of the most vulnerable members of society are treated, the ethical questions pertaining to tube feeding more generally are as great and varied as the circumstances and types of tube feeding. As Fr. Myles Sheehan, S.J., M.D. reminds us, the case of a person living in a persistent vegetative state is only one of many circumstances in which tube feeding is indicated, and one that is less common than others.⁹ Thus, in seeking the mean between extremes, we have a responsibility not to let the issues surrounding one fairly rare circumstance of tube feeding provide the paradigm in which we make decisions regarding tube feeding in all other circumstances.

NOTES

1. Regarding hand feeding versus tube feeding, see "Hand Feeding Delivers Compassionate Palliative Care," *Catholic Health World*, 24, 8 (2008), May 1.
2. Regarding these and other reasons for the use of tube feeding, even when it may not be the best clinical choice, see Gillick, MR, and Volandes, AE, "The Standard of Caring: Why Do We Still Use Feeding Tubes in Patients with Advanced Dementia?" *Journal of the American Medical Directors Association* 9 (2008): 364-367.
3. Regarding the different types of tube feeding, see Bowers S, "All About Tubes: Your Guide to Enteral Feeding Devices," *Nursing* 30, 12 (2006):41-7.
4. Metheny, NA, Meert, KL, and Clouse, RE, "Complications Related to Feeding Tube Placement," *Current Opinion in Gastroenterology* 23 (2007): 178-182.
5. Cervo, FA, Bryan, L, and Farber, S, "To Peg or Not to Peg: A Review of Evidence for Placing Feeding Tubes in Advanced Dementia and the Decision-Making Process," *Geriatrics* 61, 6 (2006): 30-35; and Sheehan, M, "Feeding Tubes: Sorting Out the issues," *Health Progress* 82, 6 (2001): 22-27.
6. Carey, TS, Hanson, L, Garrett, JM, et al. "Expectations and Outcomes of Gastric Feeding Tubes," *JAMA* 119, 6 (2006):527.e11-527.e16.
7. Carey, "Expectations and Outcomes of Gastric Feeding Tubes," 527.e14. See also, Roche, V, "Percutaneous Endoscopic Gastrostomy: Clinical Care of PEG Tubes in Older Adults," *Geriatrics* 58, 11 (2003): 22-29; and Finucane, T, Christmas, C, Travis, K, "Tube Feeding in Patients with Advanced Dementia: A Review of the Evidence," *JAMA* 282, 14 (1999): 1365-1370.
8. Gillick, "The Standard of Caring: Why Do We Still Use Feeding Tubes in Patients with Advanced Dementia?," *Journal of the American Medical Directors Association* 9 (2008): 365-366.
9. Sheehan, "Feeding Tubes: Sorting Out the Issues," *Health Progress* 82, 6 (2001):22.