QUESTIONS AND ANSWERS REGARDING ASSISTED NUTRITION AND HYDRATION

By Chris Kahlenborn, MD

The specific question of whether to place a stomach tube in a patient who has had a stroke or has advanced dementia is one of the most difficult dilemmas for patients and/or family members who often have questions regarding the ethics of either giving or withholding assisted nutrition and hydration (ANH). As a board-certified internist with 28 years of medical experience, Dr. Chris Kahlenborn answers some basic questions regarding the issues involved in the decision of whether to provide assisted nutrition and hydration (ANH) to the patient(s) in need. Dr. Kahlenborn is a Catholic physician who clearly articulates the Catholic Church's teaching regarding ANH. His practical medical advice respects the sanctity of human life and applies regardless of one's faith tradition

Q1: What do you mean by assisted nutrition and hydration (ANH)?

ANH is the delivery of nutrition and/or hydration to a person via an assisted means of delivery such as via a person's veins, often called TPN (total peripheral nutrition) or via a tube that goes into a person's stomach, called a PEG tube (percutaneous endoscopic gastrostomy tube).

Q2: What does the Catholic Church teach in regard to ANH?

The teachings of the Catholic Church support the use of ANH except in those rare cases when death is imminent or when ANH may do more harm than good. For example, the United States Conference of Catholic Bishops (USCCB) cited Pope John Paul II's address (March 20, 2004) regarding people in the so -called "vegetative state," noting: "1) Patients who are in a 'vegetative state' are still living human beings with inherent dignity, deserving the same basic care as other patients; 2) nutrition and hydration, even when provided with artificial assistance, are generally part of that normal care owed to patients in this state, along with other basic necessities such as the provision of warmth and cleanliness."

Q3: Can assisted nutrition harm a patient?

It is possible, albeit rare, that ANH can harm a patient. For example, a patient with severe congestive heart failure may not be able to tolerate fluids for a period of time, or a patient who has cancer in the abdomen may not be able to tolerate a PEG tube. However, I have found that in more than 99% of cases assisted nutrition and hydration is beneficial, and I have rarely seen a case in which giving fluids or assisted nutrition harms the patient.

Q4: Most hospitals have palliative care teams and/or hospice nurses/physicians. What role do they play on the issue of ANH?

I have found that, in general, hospice and palliative care personnel try to dissuade patients from assisted nutrition and hydration. In my opinion, the reasons for this vary. Unfortunately, financial pressure often plays a significant role. Patients who forego ANH are frequently transferred to

hospice centers and die within days from dehydration, thereby allowing hospitals to reduce their lengths of stay. In addition, insurance companies save money when a patient foregoes ANH since they do not have to pay the many expenses involved in treating these fragile patients. Today, insurance companies are actively putting pressure on hospitals to increase their number of palliative care consults, which is quite revealing.

Q5: Can you give a common example of when this conflict may arise?

I personally have seen this issue most often in patients who are not able to swallow for the first few weeks after they have had a stroke and sometimes for longer periods. Often a family member will note that the patient has a living will. If the patient cannot communicate well at this point in time, the decision may be made that food and water are considered "extraordinary." The tragedy is that many of these patients could recover if they were to receive short-term parenteral nutrition (i.e., intravenous food and water) for a few days or weeks.

Q6: Some doctors claim that ANH does not prolong life. Is this true?

Many doctors cite studies in the medical literature that support the claim that ANH does little to decrease a patient's mortality or increase quality of life. The medical literature has become highly politicized over the past two decades. My impression as a physician and a researcher is

that some studies which are favorable to ANH are likely excluded from publication due to editorial bias. In addition, studies, where one measures mortality by comparing patients with dementia who receive ANH to those who do not receive ANH, may suffer from selection bias, since the patients who require ANH are often far sicker than those who do not require ANH and are, by definition, at higher risk of mortality. A recent article in the August 2016 Linacre Quarterly entitled "Is tube feeding futile in advanced dementia?" by Dr. Matthew Lynch addresses these issues nicely.

Q7: Is it painful to die from dehydration and nutrition?

Some practitioners have the arrogance to state rather definitively that dying from dehydration is not painful. But, how can anyone know what a patient in this state is experiencing unless they themselves have experienced it? Anyone who has been moderately to severely dehydrated has noted the phenomenon of stinging eyes, dry skin, burning urine, and pain with swallowing. It would follow that the patient who is no longer given water would experience similar symptoms.

Q8: Patients often have living wills that state that they do not want feeding tubes if death is imminent. Does this apply to the stroke and dementia patients who are developing dehydration?

No. In general, this does not apply and it is very confusing for patients. Death only becomes imminent in most stroke and dementia patients if ANH are withheld. If ANH are given, death is usually not imminent.

Q9: Is it good to have a living will?

Many people, often under the guidance of their lawyer, have living wills which specify what type of medical treatment they wish to have or forego should they have a terminal illness. There are several problems with this. First, the living will is a rather rigid document, often prepared years prior to the occurrence of the patient's first medical illness, after which circumstances and opinions have often changed. Second, many physicians interpret a living will as a "do not resuscitate (DNR)" order, so that, if you are admitted for a non-terminal illness, you could be categorized as a DNR patient, when that may not be your wish. Third, patients with living wills, in general, will get less aggressive hospital treatment. My advice is to speak with a trusted friend or family member and make them your power of attorney for healthcare decision maker instead of obtaining a living will.

Q10: Can Catholic physicians, physician's assistants, nurses and pharmacists do anything to promote the teachings of the Church?

In my personal experience, the best one can do is to offer the patient and their family the teachings of the Church and try to get a more traditional Catholic priest or deacon to consult with the family. Often these families are misguided but well -intentioned. If the case becomes too problematic for the physician, he or she may have to recuse himself or herself from the case. I have had to do this on rare occasions, but have also noted that many families and patients will work with the physician if the physician offers them compassionate care and gives them time to consider their options (e.g., giving a few weeks of TPN after a stroke while they think about the decision to use a PEG if needed for the long term).

Q11:Would it help if there were a more specific statement from the Church regarding ANH?

I think it would help if a more specific statement were made by the Church, especially since this is such a confusing area for the public and for most Catholics, including physicians. I suggest the following statement, which several theologians/scholars* have reviewed and believe is consistent with Church teaching**:

"The Church rejects either the act or omission which, of itself or by intention, causes death in order to eliminate suffering; therefore, any omission of nutrition and hydration, by itself or with the intention to cause or hasten a patient's death, must be rejected. Therefore, we must hold for a presumption in favor of providing nutrition and hydration for every patient -especially the dementia or stroke patient who receives hospice, comfort or palliative care.

If a patient is not able to sustain himself (herself) by oral intake of food and water, then assisted nutrition and/or hydration (e.g., intravenous fluids, total peripheral nutrition {TPN} and/or a PEG tube) should be offered and should not be withheld or considered burdensome except for rare exceptions in which they could acutely worsen a person's medical outcome (e.g., giving intravenous fluids to a patient who is experiencing an acute episode of congestive heart failure). These measures are ordinary treatments and therefore cannot be based on a person's "quality of life."

Patients who suffer from dementia or stroke should not die due to dehydration and/or malnutrition.

The symptoms of dehydration should be treated with oral or assisted fluids and not via pain medications or sedatives such as morphine or lorazepam."

*William E. May, theologian (deceased); Fr. James Buckley, theologian; Professor Dianne N. Irving, Bioethicist; Professor Robert P, George, Princeton University, Professor of Jurisprudence

**The assistance of my friend and colleague Mr. Mark Chuff in the preparation of this statement is greatly appreciated.

Q12: Are there dangers to placing a stomach tube or giving TPN?

The placement of a stomach tube is a relatively low -risk procedure that takes about 30 minutes to perform and is done under sedation. In addition, a stomach tube can be easily removed if a patient is able to eat again. The administration of TPN is also quite routine and can be done via a special IV placed in the patient's forearm, termed a PICC line, which is also a very low-risk procedure.

Q13: Should cancer patients generally get ANH?

Most oncologists believe that, if you have cancer, it is not a good idea to place a feeding tube as it "may feed the cancer." However, there is little support for this statement in the medical literature. There may be certain times when ANH can be very useful in the patient with cancer, such as for those with mechanical obstructions (e.g., patients with esophageal cancer) or those with prolonged nausea from chemotherapy.

Q14: Can the medical literature be trusted in regard to ANH?

In my 28 years of practicing medicine, I have noted that the medical media (including most medical journals), most medical associations, and the lectures given at large annual conferences have increasingly leaned toward positions that are aligned with the culture of death. Researchers are under great pressure to publish findings that support this death culture and may have their grant money (i.e., usually given by the National Institute of Health or National Cancer Institute) "dry up" if they do not conform. In light of this, I am personally very skeptical of the findings noted in today's medical journal articles in relation to ANH. Sadly, the older medical literature, that is, studies from more than 20 years ago, although dated, are often more candid about their findings and seem to be less influenced by political correctness.

Q15: What can a patient/family do if they think they are being pressured by a hospital or physician to forego ANH?

Sometimes the best first step is to try to get some ANH, such as TPN, started while the decision regarding a PEG tube is being considered. If you are still pressured by your doctor, do not be shy about stating that you are being discriminated against due to your religious beliefs and to speak with an administrator citing this specific claim (i.e., religious discrimination). If ANH is still being denied, you may have to resort to the threat of legal action and consider the transfer of your loved one to another hospital.

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