LETTERS TO THE EDITOR

Biased Selection in Tube Feeding Study?

To the Editor:—In the article by O'Brien et al.¹ regarding feeding tubes, nursing home residents were asked to read two statements and show some understanding of them before inclusion in the study. They were then interviewed regarding their feeding tube preferences. The study found a higher preference for feeding tube placement, and less resistance to the use of restraints to prevent feeding tube removal, than in previous studies. I am troubled by the selection process used by O'Brien et al. to identify study participants. I perceived a bias in favor of feeding tube placement on the part of the investigators that could have easily influenced patients' responses to study questions and led to the above findings.

The first statement read in part: "When a person cannot swallow or digest food normally they *have to* be given food through a tube in the stomach . . . If someone cannot eat and does not receive tube feedings, *they will die*. Tube feedings usually do not cause pain" (emphasis added). I know of no medical intervention a patient has to receive, unless refusal of the intervention puts others at risk of harm. However, the implication here is that the patient has no choice but to have a feeding tube placed.

The statement that without a feeding tube a patient will die is at best a partial truth. Although the feeding tube may forestall death, it may also do nothing to improve the patient's quality of life. A discussion about extending life without consideration of the quality of that life is clearly inadequate.

Finally, the statement that feeding tubes do not cause pain ignores the other known complications of feeding tubes. These include infection, volume overload, and aspiration pneumonia.

Potential study participants were then shown two virtually identical drawings of a sleeping patient, the only difference being a restraint on the wrist of one patient. They then read a passage that began, "Sometimes people who are confused try to pull the feeding tube out." I have long suspected that patients who try to remove feeding tubes are if anything quite clear-headed about their desire not to extend a life of inadequate quality when all they gain is a prolonged death. Furthermore, the drawing of the restrained patient in no way resembled the patients I have ob-

served who become entangled in bed sheets and IV lines as they try to become free. Rarely have I seen patients accept restraint with such equanimity as depicted in this picture.

As they are written, I think the above statements and the accompanying pictures subliminally promote feeding tube placement and may have influenced the study results. I suspect these results would have been considerably different had the authors been more objective in their selection process.—**LAURA H. BRACHMAN, MD**, *The Genesee Hospital, West Henrietta, NY*.

REFERENCE

1. O'Brien LA, Siegert EA, Grisso JA, et al. Tube feeding preferences among nursing home residents. *J Gen Intern Med*. 1997;12:364–71.

In reply:—We strongly agree that discussions about the use of life-sustaining technologies without proper consideration of quality-of-life issues are inadequate at best.

We also concur that there is a crucial need for society at large to grapple with the limits of medicine and to define what constitutes humane end-of-life care.

Our research question, however, was not directed toward answering these philosophically complex issues, but rather toward the pragmatic application of the standard, as set forth in the Patient Self-Determination Act, that all individuals have the fundamental right to accept or forgo life-sustaining treatment.

We believe that we went far beyond the norm of most clinical settings not only in requiring that nursing home residents understand the nature of tube feedings but also in acknowledging that tube feedings frequently are used to keep alive individuals who have permanent brain damage. Although our treatment descriptions and illustrations may be criticized as having been overly hygienic, our goal was to provide standardized information about the technical aspects of tube feeding in a neutral and unbiased fashion while meeting current federal standards.

We also point out that many nursing home patients witness first-hand many patients receiving tube feedings and may, therefore, believe that tube feedings must be the "right thing to do." The situation is very different for CPR. We need to evaluate whether it is appropriate to offer all patients the choices of CPR or tube feedings regardless of health status, as we believe there are biases implicit in merely asking the question.—**LINDA A. O'BRIEN, RN, MA**, *The Cooper Health System, Camden, NJ*, and **ELISABETH SIEGERT, MD**, *University of Medicine and Dentistry of New Jersey, Robert Wood Johnson Medical School, Camden, NJ*.

The Physician and Pharmacist Team

To the Editor:—Bogden et al.¹ discuss a very important issue—the failure of physicians to meet goals for serum lipid levels, as set by NCEP guidelines. They show that in 94 hyperlipidemic

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patients in a resident outpatient clinic setting, a 30-minute meeting with a pharmacist prior to each office visit over a 6-month period results in superior success in reaching goals for patients' lipid levels. The control arm of the trial is a similar resident clinic without the pharmacist meetings. These data show that in the study setting, the addition of a pharmacist to the health care team significantly improves the management of hyperlipidemia in a way that could benefit the patient.

It would be nice to know what aspects of patient care are addressed by the pharmacist intervention. For example, meeting with the pharmacist may have improved patient compliance with dietary advice and medication, an important factor. It appears, however, that at least part of the difference between the two groups is that the pharmacists better followed *published and widely accepted* standards of care. For example, only 9 of 47 control patients had hepatic enzyme panels, versus 35 of 47 in the intervention arm, despite recommendations that liver function tests be monitored 6 and 12 weeks after initiation of statins or niacin. Similarly, only 67 lipid profiles were ordered in the control group over 6 months, versus 108 in the intervention group, suggesting that the pharmacist worked harder at meeting NCEP guidelines by titrating the medication dosing more rapidly.

Although the authors show that the pharmacist could improve the care of hyperlipidemic patients, this may not be practical. It would be preferable to improve physician performance. One recent approach to this is through the use of disease management protocols, which are user-friendly and updated, charted guidelines designed by a health system to assist the primary care physician in delivering excellent care in a time-efficient manner. Perhaps this approach would be superior to delegating to allied health professionals what should be in the hands of the physi-

cian.—**ROBERT K. CATO, MD**, *University of Pennsylvania Health System, Philadelphia.*

REFERENCE

1. Bogden PE, Koontz LM, Williamson P, Abbott RD. The physician and pharmacist team: an effective approach to cholesterol reduction. *J Gen Intern Med.* 1997;12:158-64.

In reply:—This study demonstrated the effectiveness of physician-pharmacist teamwork in managing hypercholesterolemia. The study focused on the adult subpopulation with total cholesterol more than 240 mg/DL within 6 months of study inception. Patients having cholesterol controlled below this level by their physicians within 6 months of study inception were excluded from entry.

It should be emphasized that in this study, the physician retained authority to manage hypercholesterolemia. The pharmacist functioned as a consultant who made recommendations to the physician. We agree that the preferred approach to physicians' failure to meet widely accepted standards of care is to improve physician performance. One effective way of doing so may be to use a pharmacist as a consultant to remind physicians to apply accepted guidelines.

A second function of the pharmacist in this study was to interact directly with patients to encourage compliance and answer questions about medications. Was the improved performance of the physician-pharmacist team due to the pharmacist interacting with the physician or with the patient? This dilemma clearly represents an opportunity for further research.—**PAUL BOGDEN, MD**, *John A. Burns School of Medicine, Honolulu, Hawaii.*