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Informed Decision-Making Surrounding the Use of Chronic Enteral Nutrition: Let's Talk the Talk

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Artificial nutrition through tube feeding is not unusual among persons with end stage dementia. It is estimated that about one-third of nursing home residents with advanced dementia are tube fed.¹ This occurs even though the cited benefits of use, prolonging life, preventing aspiration, healing pressure ulcers, and providing comfort, do not appear to be supported by available evidence.^{2,3} The decision to place a feeding tube frequently occurs in an acute care setting and is made by a health care team that has not had a long standing relationship with the patient and family.⁴ Recommendations by the team are then often based on a “snapshot” of the patient so that appropriate medical decision-making is more challenging.

The current study in the *Journal* by Swaminath et al reports one attempt to meet this challenge by an intervention including a series of targeted seminars for health care providers (physicians, nurses, social workers, nutritionists, and speech therapists) that are involved with tube feeding decisions and the provision of a new consultative service.⁵ The service specialized in goals of care conversations, so that patients and families facing a tube feeding decision could receive counsel on the short and long term risks and benefits of the procedure. The intervention was associated with a nearly 50% decrease in feeding tube placement rate over a one-year period. This decrease was not associated with a change in 30 day, 1-year, or 2-year mortality. The absence of a mortality difference between groups suggests these conversations are not associated with a “rationing” or “limiting” of care but lead to more informed decisions.

The dramatic decrease in tube feeding rates was limited to one hospital where Kaiser System members receive most of their acute care. The program also benefited from a dedicated and highly visible local champion. It is unclear whether such a program would lead to similar declines in tube feeding rates in other, more fragmented health systems. Another caveat to consider is that the actual number of patients facing a tube feeding decision remains unknown. The decrease in tube feeding rates may reflect secular trends, such as greater hospice use in the community, in addition to the effects of the intervention.

The high mortality rate is consistent with other prospective studies of tube fed populations.^{2,3} This supports the argument that a large portion of tube feeding decisions occur in persons with advanced illness near the end of life. However, patients and families report that health care providers generally only discuss procedural risks without addressing other components of the patient's care so that tube placement seems a forgone conclusion.⁴ To counteract this default approach, innovative programs such as the one outlined in the current study advocate for informed decision making including conversations with patients and families that openly discuss prognosis and health care wishes.

At the same time, it is also important to recognize that not all persons facing a tube feeding decision have a uniform prognosis as is evidenced by the fact that about 40% of patients in this study were living 2 years after the decision. Also, some patients with a limited life expectancy, such as those with amyotrophic lateral sclerosis, derive benefits from tube feeding such as improved nutritional status, quality of life, and possibly prolonged survival.⁶ Taken together, decisions about chronic enteral nutrition involve uncertainty and require a thoughtful approach such as that described in the current study.

The need for consultation by persons experienced in goals of care conversations have contributed to the dramatic growth of palliative care in academic and community hospitals. Palliative care providers acquire competence in ascertaining the medical, psychological, social, and spiritual dimensions of the patient and family so that these can be incorporated into the care plan. Communication skills also contribute to optimal goals of care conversations and include being aware and making use of nonverbal cues, responding with empathy, employing humor appropriately, as well as learning techniques to negotiate conflict. Conversations exploring the goals of care benefit from the extensive training of palliative care providers and are time consuming, typically taking several visits each of which can last an hour or more.

As the US population ages and financial pressure from escalating health care costs continues, particularly in the last year of life, professionals trained in goals of care conversations will become an increasingly important component of inpatient medical care. The study by Swaminath et al attests to the impact provider education and patient and family counseling can have on medical decision-making in this instance, greatly reducing the placement of feeding tubes but not affecting mortality.

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