Medical Ethics and Nutrition at the End of Life

Maureen McCarthy, MPH, RD, CSR, LD
Fresenius Kidney Care---St Helens, OR

Oregon Geriatrics Society
October 9, 2016

Maureen McCarthy has no relationship(s) to disclose.
OHSU’s Fellowship in Interprofessional Health Care Ethics

Fellow
Class of 2012-2014

Second Year Project:
To increase awareness of advantages and disadvantages of artificial nutrition and hydration (ANH) at the end of life

OBJECTIVES

• At the end of this session, the participant will be able to
  – Examine landmark cases related to end-of-life decisions which included nutrition issues (Quinlan, Cruzan, Schiavo).
  – Describe and apply the Jonsen model ("four box model"), which organizes case details to assist in end-of-life decision-making
  – Identify potential benefits and hazards of artificial nutrition and hydration (ANH) at the end-of-life
Professional Background—Maureen McCarthy, MPH, RD, CSR, LD

- 10 years in public health—WIC Nutritionist
  - In East Palo Alto and in Los Angeles
- 31 years in ESRD
  - Adult hemodialysis in Lewiston, ME
  - Adult hemodialysis and peritoneal dialysis in greater Portland, OR
  - Solid abdominal organ transplant team at OHSU
  - Adult hemodialysis in greater Portland
- 10 years on staff of OHSU’s Dietetic Internship Program in SOM

Artificial Nutrition and Hydration (ANH)

ANH is provided by a “non-oral” route. It may include:

- Nutrition provided via
  - Feeding tube of any kind, by any route
  - Intravenous route
- Hydration or fluid support provided via
  - Feeding tube of any kind
  - Intravenous route
  - Subcutaneous hydration (hypodermoclysis)

Martin DM. Hypodermoclysis: renewed interest in an old technique. Consult Pharm. 2010; 25:204-212.
Ethical Issues at the End of Life

- Withholding or withdrawing of medical interventions
  - These include ANH
  - Withholding and withdrawing—morally equivalent
    - Consider the word “foregoing”
- Goals of care: palliative and/or hospice
  - Pain & symptom management
- "DNR/DNI” or "Allow Natural Death"
- Medical futility
  - Further treatment is of no benefit
- Burden of suffering
  - Adequate pain management must be provided even if it produces the “double effect”

Case Study

49-year-old male with end-stage lung cancer
- He is being admitted to hospice care center
  - Wife is his caregiver at home
- On continuous oxygen, routine pain medications
- Frail, cachectic, sleeping most of the day
- Taking 8-10 oz fluid/day
  - Wife/caregiver requests IV hydration and nutrition consult
    - Concerned her husband will die of dehydration

Georgetown Principles of Medical Ethics
By Beauchamp and Childress
• Autonomy
  — To allow and respect individual choice
• Justice
  — Health care, resources must be distributed fairly and equally
• Beneficence
  — Do good to the patient (i.e., prevent pain, incapacity)
• Non-maleficence
  — Avoid harm to the patient ("First, do no harm")
  — Minimize illness
  — Avoid futile interventions


Jonsen Model for Decision Making
Also called the “4 box model”
Characteristics of the case are assigned to an appropriate “box” —
• Medical Indications
• Patient Preferences
• Quality of Life
• Contextual Features

### Medical Ethics: The Science of Doing Good

#### JONSSON MODEL:

<table>
<thead>
<tr>
<th>CASE ANALYSIS</th>
<th>MEDICAL INDICATIONS</th>
<th>PATIENT PREFERENCES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medical Ethics</td>
<td>Causality Principle</td>
</tr>
<tr>
<td></td>
<td>- Autonomy</td>
<td>- (Case based)</td>
</tr>
<tr>
<td></td>
<td>- Beneficence</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Non-Maleficence</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Justice</td>
<td></td>
</tr>
</tbody>
</table>

#### Recommendations:

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
</table>

---

### “The four boxes”

- **Medical indications**
  - Enter each medical condition and proposed treatment: does it fulfill a goal of medicine?

- **Patient preferences**
  - What does the patient want? Does the patient have DM capacity?
  - Does patient have POLST or Advance Directive? Who can speak for the patient? Informed decision?

- **Quality of life**
  - Describe quality of life in patient’s terms. What are patient’s endorsed life preferences?
  - What is patient’s subjective acceptance?
  - View of care providers?
  - Is it “less than minimal?”

- **Contextual features**
  - Social, legal, economic, institutional, cultural and faith-based factors in the case that may:
    - a) influence a decision, or
    - b) be influenced by the decision
Landmark Cases in EOL Nutrition

Karen Ann Quinlan

1975—lost consciousness after a party, possibly after consuming diazepam, dextropropoxyphene and ETOH (anorexic also?)
Ventilator- and tube feeding-dependent
Persistent vegetative state (PVS) due to anoxic encephalopathy
Parents asked to d/c ventilator, per Karen’s wishes
In 1976, NJ Court ruled that ventilator could be d/c’d, per pt wishes
Pt died in 1985, after years on tube feeding (never challenged)

Landmark Cases in EOL Nutrition

Nancy Cruzan

1983—auto accident → anoxic brain injury
• Required tube feeding for nutrition
• After several years, parents asked MO Supreme Court for permission to remove feeding tube
  -- MO Court ruling: Tube could be removed only if evidence showed she agreed
  -- US Supreme Court said states could set standards for removing feeding tubes
  -- Friends of Nancy testified that she did not wish to live via feeding tube
1990—tube was removed, Nancy died peacefully
Landmark Cases in EOL Nutrition

Terry Schiavo

- 26 F suffered cardiac arrest in 1990
- Severe brain damage
  - Diagnosed as PVS later—controversial
- PEG tube inserted
- Husband, Michael, appointed guardian
  - Filed petition to remove feeding tube
  - Parents disagreed, attempted to change order of surrogacy
  - Feeding tube removed, reinserted several times
- US Supreme Court—4 rejected appeals
- FL Legislature and Governor, US Congress intervened
- March 2005—Federal District Court would not order reinsertion of tube; pt died 13 days after her tube was pulled

Surrogate Decision-Makers

An excerpt from OHSU Health Care Policy

Surrogate decision makers: If a patient lacks capacity to provide consent or has been declared by a court or law to be incompetent, the legal guardian or legally authorized healthcare representative may provide the informed consent on behalf of the patient. Those who may provide consent on behalf of the patient who lacks capacity are (listed in order of authority):

a) A legal guardian
b) A surrogate of the patient who is appointed by an Advance Directive to make health care decisions
c) The patient's spouse or registered domestic partner
d) An adult designated by the others listed in this subsection who can be located, so long as no person listed in the subsection objects to the designation
e) A majority of the adult children of the patient who can be located with reasonable effort
f) Either parent of the patient
g) A majority of the adult siblings of the patient who can be located with reasonable effort
h) Any adult relative or adult friend
i) The attending physician in consultation with the Patient Advocate and a member of the nursing staff


Bolded individuals are listed as surrogate decision makers in Policy HC-RI-102-RR when legally authorized health care rep not available. Consent. Effective 8-27-2014.
Nutrition at the EOL

- **Patient Self-Determination Act, 1990**
  - Pt and family may decline artificial nutrition (and other life-sustaining treatments) when EOL is approaching
- **Dietitians’ duty**
  - To know patient’s wishes
  - To provide most appropriate care
  - To understand the current treatment plan developed by patient/family/team
    - Work with the care team to support patients/families with accurate information about nutrition options
    - Nutrition options may include foregoing oral, enteral, and/or parenteral nutrition and hydration

Presumed Consent for ANH

Oregon statute (ORS 127.580) presumes consent unless:

- Individual stated while competent they did not wish ANH
- ANH not medically feasible and/or would cause severe, long-lasting or intractable pain
- An Advance Directive or legal surrogate declines it
- State of permanent unconsciousness
- Terminal condition and no decisional capacity
- Progressive illness, unable to communicate, swallow safely, or care for self; and unlikely to improve

Academy of Nutrition and Dietetics

  Authors: Julie O’Sullivan Maillet; Denise Baird Schwartz; Mary Ellen Posthauer
  - “When in doubt, feed…”
  - Feeding can be discontinued if authorized by patient or surrogate
  - Team must explain benefit (or lack thereof) of feeding or hydration
    - Feeding starts when patient medically stable, continues until treatment is futile

American Medical Association

- Patients have right to participate in decisions
  - Patients can refuse medical treatments of all types
  - Life-sustaining treatments should create medical benefit and should respect pt preferences
- ANH is a medical treatment
  - May be withheld or withdrawn ethically upon patient request
    - MDs must respect right of individuals to decline treatment
    - Withholding/withdrawing treatment may be consistent with beneficence and nonmaleficence


Accessed 9-11-16
Speech-Language Pathologists


• EOL care is interdisciplinary
• Legal and ethical considerations govern end-of-life care and decision making
• Resources from American Speech Language Hearing Association
  — http://www.asha.org/slp/clinical/endoflife/

Hospice and Palliative Nurses’ Association

• ANH interventions were intended to provide a “bridge” from acute illness to recovery and/or prolong life
• Goal of palliative care and hospice care is to minimize suffering and discomfort
  — Evidence shows ANH does not prevent suffering in terminally ill individuals with advanced illness
• ANH decisions at EOL must consider financial, sociocultural, and spiritual framework for the patient/family
• When patient cannot make decisions, consult Advance Directive and surrogate decision makers

American Geriatrics Society

SPECIAL ARTICLES

American Geriatrics Society Feeding Tubes in Advanced Dementia Position Statement

American Geriatrics Society Ethics Committee and Clinical Practice and Models of Care Committee


Hand feeding -- as good as tube feeding for the outcomes of death, aspiration pneumonia, functional status, and comfort

Tube feeding associated with agitation, more physical and chemical restraints, new pressure ulcers.

Heather Mayrros examines Mary, a ninety-two-year-old woman, at her home, in Marine Park, Brooklyn, in September, 2015. Mary died later that month. Heather believes in caring for the whole person, body and mind.

Terminal Illness

Progression includes

• Decreased interest in food
  – Declining food and fluid intake
• Weight loss
Artificial Nutrition and Hydration

"But, I don’t want my Mom to starve".

Role of ANH in EOL Nutrition

• Consider
  – Will ANH improve/sustain quality of life?
  – What does the patient want? What personal values are affecting this choice?
  – What does it feel like to go without food or recommended fluid intake when death is near?
Clinical Considerations With ANH

• Issues of feeding tube insertion
  – Beneficence vs. non-maleficence
  – Autonomy
    • Most Americans do not want feeding tube at EOL
• Using restraints if patient tries to remove feeding tube…?
  – Nursing home residents with DMC, given hypothetical case study of brain-injured status, declined feeding tube if restraints used
    • Wanted staff to respect patient wishes--Autonomy
• Risk of infection with central lines
  – Beneficence vs. non-maleficence


Hydration

• Is it more merciful to give a dying patient fluid than to let her/him experience dehydration?

Hydration

• Artificial hydration may have some disadvantages for someone near death
  — Possible increased GI fluids
    • Abdominal distention, N/V
    • May need NGT for gastric suctioning
  — Possible respiratory distress
  — Increased urine output
    • Pt cannot ambulate, might need Foley
• Dehydration may cause electrolyte shifts
  — May see neuromuscular irritability, twitching, restlessness


Hydration

Medically assisted hydration for palliative care patients

• Patients with artificial hydration had
  — More involuntary muscle contractions
  — More pleural effusions, peripheral edema, ascites

• On-going high-quality study should give more guidance

Dehydration At End of Life

Results from natural factors associated with end-stage illness

• Body uses decreased thirst to reduce fluid load
  – Less work for circulatory and renal systems
  – Less swelling
  – May be more drowsy
  – Dehydration leads to endorphin release


Dehydration At End of Life

Painful? Or Palliative?

When death is near, dehydration may

• Reduce pharyngeal secretions
• Reduce risk of peripheral and/or pulmonary edema
• Reduce urine output
• Create CNS sedative effects due to metabolic changes

This may provide less distress.
Palliative care standards switching to non-hydration at EOL.

The Role of Good Oral Care

Good oral care is essential for EOL patient who is not receiving hydration via alternate route:

• Maintain oral moisture
  – Mouth swabs, ice chips, sips of favorite beverages
  – Artificial saliva spray available by rx

• Avoid drying agents (glycerin, lemon juice)
  – Lip balm may help

• Remove mouth debris
  – Brush tongue, gums, teeth with soft toothbrush

Zerwekh, JV. Nursing, 1983; 13:47-51

Hunger At End of Life

Absence of food and fluid results in

• Ketosis and release of opioids in the brain
  – May contribute to a sense of euphoria

Research re: Hunger at EOL

- At EOL there is less awareness of hunger, thirst

- Prospective evaluation of 32 terminally ill patients admitted to a comfort care unit in LTC center
  - Diet orders liberalized, patients ate “as desired”
  - By end of study, 100% of patients reported no hunger
    - 1/3 of patients reported hunger initially
  - 2/3 reported no thirst with ad lib fluids
    - Dry mouth treated with ice chips, good mouth care

“Recreational” Eating

Recreational Eating = allowing a patient to eat as desired (also called "pleasure eating")

- Appropriate at EOL
- Assistance with oral feeding—evidence-based
  - Focus on comfort and human interactions
  - Experts suggest providing finger foods as source of comfort, pleasure
ANH and Life Expectancy

Without food and hydration, death may occur in 3 to 21 days.

ANH And Outcomes In The U.S.

Advanced dementia in US—well-studied

• Feeding tubes did not
  – Reduce aspiration risk
  – Reduce pressure ulcer (PU) incidence or improve healing
  – Lead to improved ADL functioning
• Study of tube feeding vs. palliative care intervention
  – Mortality rates equal in both groups
  – Family members seem to recognize this—less TF requests

Span P. The decline of tube feeding for dementia patients. NYT. 2016; August 30.
ANH And Outcomes, continued

• Enteral feeding in 67 pt with advanced dementia
  – Tube feeding associated with hypoalbuminemia and pneumonia
  • Thus associated with increased mortality
• Feeding tubes associated with
  – Increased PU development due to immobility
  – Using more physical and pharmacologic restraints
  – Patient distress regarding feeding tube
• Families do not understand that tube feeding does not increase life expectancy in advanced dementia


Tube Feeding in US Nursing Home Residents with Advanced Dementia


<table>
<thead>
<tr>
<th>Year</th>
<th>Residents with Advanced Dementia</th>
<th>With Recent Oses of Total Dependence for Eating, %</th>
<th>With Feeding Tubes Over Subsequent 12 Months, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>7029</td>
<td>820 (11.7)</td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td>6738</td>
<td>774 (11.5)</td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>6329</td>
<td>701 (11.4)</td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>5518</td>
<td>577 (10.5)</td>
<td></td>
</tr>
<tr>
<td>2004</td>
<td>5194</td>
<td>462 (8.9)</td>
<td></td>
</tr>
<tr>
<td>2005</td>
<td>4628</td>
<td>398 (8.6)</td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>4389</td>
<td>393 (9.0)</td>
<td></td>
</tr>
<tr>
<td>2007</td>
<td>4110</td>
<td>357 (8.7)</td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>3890</td>
<td>331 (8.5)</td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td>3842</td>
<td>307 (7.7)</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>3794</td>
<td>283 (7.5)</td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>4528</td>
<td>264 (5.8)</td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>4246</td>
<td>235 (5.5)</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>3685</td>
<td>207 (5.6)</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>3411</td>
<td>193 (5.7)</td>
<td></td>
</tr>
</tbody>
</table>
Tube Feeding in US Nursing Home Residents with Advanced Dementia


<table>
<thead>
<tr>
<th>Race</th>
<th>2000</th>
<th>2014</th>
<th>Difference (95% CI)</th>
<th>Risk Ratio (95% CI) Unadjusted</th>
<th>Risk Ratio (95% CI) Adjusted</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>31.7</td>
<td>5.7</td>
<td>-26.0 (-31.6 to -20.5)</td>
<td>0.45 (0.41 to 0.50)</td>
<td>0.41 (0.38 to 0.45)</td>
</tr>
<tr>
<td>White</td>
<td>8.6</td>
<td>3.1</td>
<td>-5.5 (-7.0 to -4.3)</td>
<td>0.37 (0.31 to 0.43)</td>
<td>0.37 (0.33 to 0.41)</td>
</tr>
<tr>
<td>Black²</td>
<td>37.5</td>
<td>17.5</td>
<td>-20.0 (-25.5 to -10.2)</td>
<td>0.47 (0.40 to 0.55)</td>
<td>0.47 (0.41 to 0.55)</td>
</tr>
</tbody>
</table>

*Race data were obtained from the Minimum Data Set, which categorized race as white, black or African American, Asian, American Indian or Alaska Native, Native Hawaiian or other Pacific Islander, other, and unable to determine. For this study, race data were categorized as white, black, or other.

Food Is Love

FOOD

- Powerful symbol of caring, nurturing
- Central component of social, spiritual practices

**What to say to family members...**

**“The four boxes”**

- **Medical indications**
  - Each medical condition and proposed treatment: does it fulfill a goal of medicine?

- **Quality of life**
  - Describe quality of life in patient’s terms.
  - What is patient’s subjective acceptance?
  - View of care providers?
  - Is it “less than minimal?”

- **Patient preferences**
  - What does the patient want? Does the patient have DM capacity?
  - Who can speak for the patient? Informed decision?

- **Contextual features**
  - Social, legal, economic, institutional factors in the case that can:
    - a) influence a decision, or
    - b) be influenced by the decision

---

**Responding to End-of-Life Nutrition Concerns (Appendix 2)**

<table>
<thead>
<tr>
<th>End-of-Life Nutrition Concerns</th>
<th>Possible Registered Dietitian Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Concerns of Patient</td>
<td></td>
</tr>
<tr>
<td>“My family is forcing food on me all the time.”</td>
<td>“Food is the way we all show our love for one another. They may not understand what is going on for you now. Let me talk to them.”</td>
</tr>
<tr>
<td>“Can’t you put in a feeding tube? I want more time.”</td>
<td>“At this point, it is doubtful that a tube feeding would allow you to live longer. It may cause more problems. All that fluid has to go somewhere. But let’s talk about what you want to do in the time you have.”</td>
</tr>
<tr>
<td>2. Concerns of Family Members</td>
<td></td>
</tr>
<tr>
<td>“I don’t want Mom to starve.”</td>
<td>“It is completely normal for the appetite to slow down when the end is near. Your mother is not likely to feel any hunger. Let her enjoy familiar foods she can handle herself, but let her set her own limits.”</td>
</tr>
<tr>
<td>“I’m afraid Dad will become dehydrated.”</td>
<td>“Let’s talk about that. We don’t think your Dad has much more time. Given that, you can help him by moistening his lips with sponge swabs and by keeping his mouth free of debris. He does not need to drink a specific amount of fluid every day.”</td>
</tr>
</tbody>
</table>

*End-of-life in this table means that death is anticipated in days or weeks—less than 2 mo.
†This table is based on the author’s clinical experience.
Case Study

49-year-old male with end-stage lung cancer
- He is being admitted to hospice care center
  - Wife is his caregiver at home
- On continuous oxygen, routine pain medications
- Frail, cachectic, sleeping most of the day
- Taking 8-10 oz fluid/day
  - Wife/caregiver requests IV hydration and nutrition consult
    - Concerned her husband will die of dehydration

Using the 4-box Jonsen model observe the specifics of the case inserted into the topic boxes.

Baird Schwartz D, Posthauer ME, O'Sullivan Maillet J. Practice Paper: Ethical and legal issues in feeding and hydration.
Case Study– 4-box Jonsen model

Medical Facts
- 49 y/o male
- End stage lung Ca
- Chronic O2, pain meds
- Frail, cachectic, somnolent
- 8-10 oz fluid per day
- Dehydration is extreme

Patient/Surrogate preferences
- Now enrolled in hospice
- Wife/Caregiver requests IV hydration and nutrition consult
- Previous EOL wishes indicate strong desire to avoid suffering
- An Advance Directive was completed but not yet signed

Quality of Life
- Lives at home w/caregiver (wife)
- Wife fears death by dehydration, desires to prevent death by this means
- Wants dignity for her husband and feels maintaining hydration and body habitus will achieve this goal

Contextual Features
- Ex-wife and adult children by that marriage desire no added medical intervention, including no artificial nutrition or hydration
- Patient’s wife invokes patient’s endorsed values including prolonging life; states that despite terminal condition her request for ANH should override adult children’s demands.

Case #1 Analysis

Questions ethics consultants may ask:
- What ethical principles apply in this case?
  Consider:
  - Autonomy/privacy/personhood
  - Beneficence
  - Non-maleficence
  - Justice – What is Due?

Questions health care professionals might ask:
1. Does surrogate speak for patient? Is this a case of following a standard of best interest or following the standard of substituted judgment if an advance directive exists?
2. Will ANH help or harm patient?
3. Can surrogate require health care professionals to intervene with ANH if they believe it is of no benefit?
4. Will use of term Allow Natural Death (AND) possibly help family come to terms with patient’s inevitable, and impending death?
Consider this…….

• Patient’s known preference must be followed
  • HOWEVER, health care professionals may choose to withdraw from case under the doctrine of conscientious objection.

• The unsigned advance directive demonstrates intent.

Case Study John: The Tube Feeding Spiral

• 78 year old man with DMII and moderate COPD
• Former college professor of English literature
• Lives independently in a mobile home park
• Passionate past-time: assisting at the Little League baseball fields in the summer and reading to children
• Recent Hx right hemisphere stroke w/ left side weakness, difficult walking, word-finding & sentence structure; choking w/swallowing liquid and puree food
• Recent Hx of aspiration pneumonia
Clinical interventions

- Swallowing tests and specialist evaluations, nasogastric tube (NG tube), parenteral nutrition (TPN), gastric feeding tube placement
- Patient resented these “invasive and “intrusive” treatments, slow to agree to placement
- John pulled the TPN and NG tubes each, twice and they were replaced each time. He used a straw to drink his favorite juice and coffee – and, micro aspirating frequently
- Patient’s strong desire is to return to semi-independent living and pleasure eat as tolerated, with goal of returning to Little League volunteer activities with some transportation assistance from family.

Decisions and Outcome

- Patient is determined to have decision-making capacity
- Patient temporarily improved swallowing to extent of enjoying occasional semi-solid food. Yes, still having some coughing/aspiration.
- Family supports patient’s independent requests; offers in-home support / watchful eyes to assure patient does not incur more burden of suffering.
- Discharged to home with home health RNs and family visits daily to administer tube feeding.
- One night, patient self-removed gastric feeding tube
- Soon, patient acquired abdominal sepsis; survived 6 days and expired. During these six days, patient refused Abx or other interventions.
- Can you use the Jonsen decision-making model to sort out the issues in this case?
Let’s discuss.....

Apply Jonsen model

Case Study Carrie

Carrie—63-year-old female with recurrence of endometrial stromal sarcoma of uterus. Hx incl morbid obesity (wt stable in past 12 mo), gastric bypass 5 years ago, HTN, CVA (residual L sided weakness), partial sm bowel obstruction

• Early Sept—colon and bladder resection for the tumor
  — d/c to SNF

• Late Oct—readmitted to OHSU with pelvic fluid collection, abscess
  — Nodules in liver, pelvis, abdomen
  — Unusual, very aggressive recurrence—terminal
Case Study 3, cont’d

• Single, no children, and lives alone in Newport, not emotionally close to her sisters but in touch with them after OHSU admit
  – Taught English composition in community college—loved it!
  – No local friends but aware of home health resources in Newport
  – Sister in Corvallis willing to be part of treatment plan if close to her home; other sister from California
• Inadequate oral intake
  – SLP eval determines high risk for aspiration
  – On TPN due to bowel obstruction, but “I’d love to eat
• Ambivalent about goals: “I’m fighting this” and “I want to die”

Let’s discuss…..

Apply Jonsen model
Reminder About Advance Directives

The individual/patient documents
• Her/his designated health care representative
• Treatment preferences re: tube feeding and "any other life support that may apply"

Health Care Team should be aware of an existing Advance Directive:
Is there one? Where is it located? What does it say? It must be respected as a legal document.

Summary
• Individual wishes must be respected—AUTONOMY
  —Is the individual decisional?
  —If not, who is the designated surrogate?
• ANH at EOL may carry some negative side effects
  —Will not increase life expectancy
• All health care team members can offer support to the patient and family