

**Community-wide Clinical Guidelines on  
Percutaneous Endoscopic Gastrostomy (PEGs)/  
Tube Feeding**

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**Rochester Community-wide Clinical Guidelines Initiative**

**A Collaborative of the Monroe County Medical Society**

**Rochester, NY**

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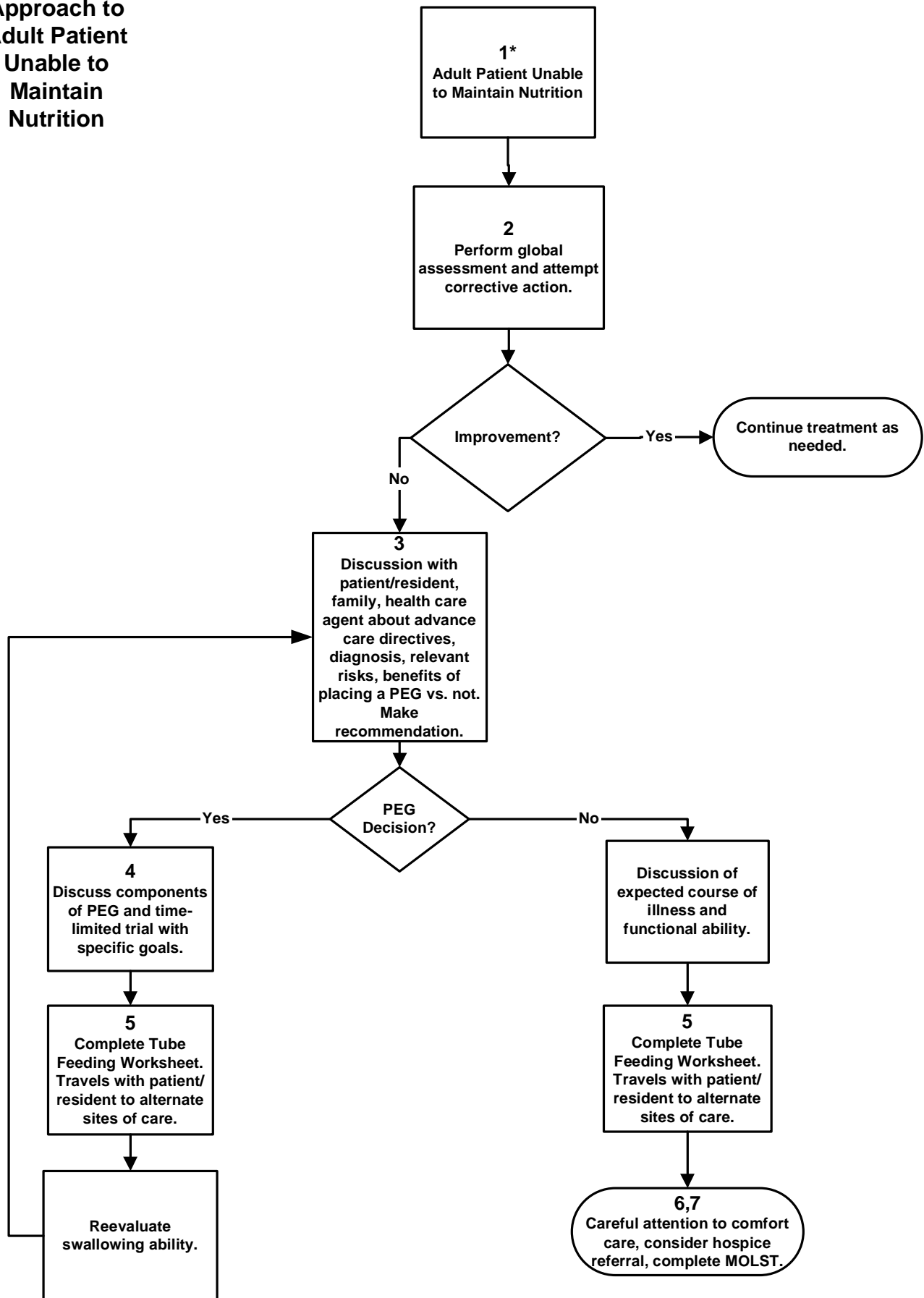
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**Approach to Adult Patient Unable to Maintain Nutrition**



\*Numbers refer to Flow Chart Reference Sheet.

# Flow Chart Reference Sheet

## 1. Triggers for Assessment of Eating/Feeding/Nutrition:

- Weight loss
- Decreased eating (> 25 % left uneaten after most meals) NOTE: Clinicians often overestimate % eaten
- Pressure ulcers
- Presence of enteral or parenteral feedings
- Apparent aspiration and/or dysphagia following, or in the setting of acute illness

## 2. Global Assessment (see Checklist for Global Assessment):

### ➤ Assess Parameters of Nutritional Status

- Weight change (1-2% or more in 1 week, 5% or more in one month, 7.5% or more in 3 months, 10% or > in 6 months)
- Account for possible fluid imbalance
- Body mass index of < 18.5 KG/meter squared
- Abnormal lab tests (albumin, pre-albumin, cholesterol, lymphocyte count)

### ➤ Identify Factors that Impede Ability to Take In Adequate Amounts of Food

- Physical limitations, visual problems
- Chewing problems (problems with mouth, teeth, dentures)
- Swallowing problems (feeding position, consistencies, bolus size, conducive environment, stimulus to swallow: verbal and tactile)
- Conditions that decrease nutrient intake (nausea, vomiting, constipation, cancer, shortness of breath, weakness)
- Alterations in taste secondary to medications, dry mouth, food options

### ➤ Identify Additional Problems in Relation to Nutritional Status

- Mental (dementia, depression, anxiety, delusions, apathy)
- Communication problems resulting in inability to make needs known
- Neurologic conditions

### ➤ Perform Medical Assessment

- Stage of illness, prognosis, pain
- Assess for constipation/fecal impaction
- Adverse medication effects
  - Address the use of medications that can adversely affect either the ability to eat or the desire to do so. Classes of such drugs include those that induce dry mouth, decrease attentiveness, provoke movement disorders and/or cause GI distress of esophagitis.
  - Specific drugs might include:
    - ❖ sedatives: lorazepam; clonazepam, etc.
    - ❖ major tranquilizers: abilify, risperidone, etc.
    - ❖ cholinergic drugs for Alzheimer's: donepezil, galantamine, rivastigmine; anticholinergics: tolterodine, oxybutynin chloride
    - ❖ GI irritants or anorexigenics: NSAIDs, COX IIs, bisphosphonates, opioids, digoxin, theophylline, antibiotics, iron, calcium, memantine, SSRIs

### ➤ Assess Hydration Status

- Urine output
- Orthostatic hypotension

## 3. Assessment of Knowledge, Values and Goals:

### ➤ Conversation with Relevant Individuals Should Include Discussion of

- their understanding of current illness, health status, functional ability
- advance directives or what the patient/individual would want if able to communicate
- hopes and concerns about future course of illness
- patient/resident values, preferences, cultural and spiritual concerns
- general goals of care (not technical options)
- all viable options for addressing nutritional problems
- placement, operation, care required of PEG
- for particular condition, proven benefits and burdens (and the likelihood of both) of placing PEG (see **Benefits and Burdens grid**)

## 4. Discuss/Describe Components of PEG:

### ➤ Discuss Time-limited Trial with Specific Goals of Care

- return to baseline level of consciousness
- acceptable level of functioning
- nutritional bridge during an acute illness
- weight gain
- healing of pressure sores
- improved biochemical markers of nutrition

### ➤ With All Appropriate Individuals, Discuss Who (and at What Interval) Will Revisit the Decision to Continue the PEG

## 5. Tube Feeding Worksheet (Should be Completed for each Patient/Resident):

## 6. Careful Attention to Comfort Care is Critical:

- Offer and assist eating if needed but do not force food
- Patient/resident preference should determine type and amount of food
- Excellent mouth care is important.

## 7. MOLST (Medical Orders for Life-Sustaining Treatment):

MOLST is a physician order form that helps health care providers honor the treatment wishes of their patients/residents. In some facilities, MOLST has replaced the DNR/DNI forms previously used. Page 2 of the MOLST form allows documentation of preferences about tube feeding. Use of one common, easily identifiable community-wide tool like MOLST (a bright pink form) leads to patients/residents receiving the care and treatment they prefer. To order MOLST forms, go to: [www.compassionandsupport.org/MOLST](http://www.compassionandsupport.org/MOLST).

# Approach to Adult Patient Unable to Maintain Nutrition Checklist for Global Assessment

\_\_\_\_\_  
Patient/Resident Name

\_\_\_\_\_  
Date of Birth

**Check each factor considered/addressed**

## Parameters of Nutritional Status

- Weight Change
- Body Mass Index
- Lab Tests: albumin, prealbumin, cholesterol, lymphocyte count
- Hydration Status (skin turgor, heart rate, BUN/creatinine)
- Urine Output
- Other: \_\_\_\_\_

Comments about above factors: \_\_\_\_\_  
\_\_\_\_\_

## Factors that Impede Ability to Take in Food

- Physical Limitations
- Pain
- Visual Problems
- Chewing Problems: mouth, teeth, dentures
- Swallowing Problems: cough after/while eating, holding bolus, pocketing, position while eating or being fed
- Nausea/Vomiting
- Constipation
- Candidiasis
- Shortness of Breath
- Dementia, Depression, Anxiety
- Communication Problems
- Neurological Conditions
- Other: \_\_\_\_\_

Comments about above factors: \_\_\_\_\_  
\_\_\_\_\_

## Medical Assessment

- Stage of Illness : advanced or end stage illness
- ADL Score: current \_\_\_\_\_
- ADL Score: 1 month prior to admission \_\_\_\_\_
- Constipation/Fecal Impaction
- Other: \_\_\_\_\_

Comments about above factors: \_\_\_\_\_  
\_\_\_\_\_

## Potential Problem Medications

- Sedatives such as lorazepam; clonazepam
- Major Tranquilizers such as aripiprazole, risperidone
- Anticholinergics: tolterodine, oxybutynin chloride
- GI Irritants or Anorexigenics: NSAIDs, COX II, bisphosphonates, opioids, digoxin, theophylline, antibiotics, iron, calcium
- Cholinergics for Alzheimer's and other dementias: donepezil, galantamine, rivastigmine
- Other: \_\_\_\_\_

Comments about medications: \_\_\_\_\_  
\_\_\_\_\_

**Additional Comments:**

\_\_\_\_\_

**Evaluating Clinician:** \_\_\_\_\_  
Name Initials Date

# Tube Feeding Worksheet

\_\_\_\_\_  
Patient/Resident Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Date

## **Complete the blanks and check all that apply:**

1. I have completed the eating/feeding/nutritional assessment and:

- No reversible factors have been identified
- Reversible factors have been identified and addressed, but eating/feeding/nutritional assessment have not shown significant improvement

2. For this patient/resident, the assessment of potential benefits of tube feeding are as follows:

- |                                 |                                    |                                     |  |
|---------------------------------|------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Likely | <input type="checkbox"/> Uncertain | <input type="checkbox"/> Not Likely | <b>to prolong life</b>   |
| <input type="checkbox"/> Likely | <input type="checkbox"/> Uncertain | <input type="checkbox"/> Not Likely | <b>to improve quality of life</b>  |
| <input type="checkbox"/> Likely | <input type="checkbox"/> Uncertain | <input type="checkbox"/> Not Likely | <b>to enable potentially curative therapy or reverse the disease process</b> |

3. Discussions have taken place with: \_\_\_\_\_

\_\_\_\_\_  
Name(s) of person(s)

About:

- understanding of current illness and prognosis (including functional recovery)
- benefits and burdens of PEGs and other treatment options
- patient's/resident's advance directives, prior wishes, values, cultural & spiritual concerns, if any, and goals of care (rather than technical options)

4.  Discussions about the above areas have been documented in the chart

5. Tube Feeding:  **WILL** be started  **WILL NOT** be started

6. **FOR PATIENTS WHO WILL START TUBE FEEDING:**

- The tube feeding decision is based on:
  - prolonging life
  - improving quality of life and/or functional status
  - enabling potentially curative therapy or reversing the disease process
  - other \_\_\_\_\_

**Because the benefits or failures of tube feeding are likely to occur within 3-6 months following placement, periodic reassessment is most important.**

- The initial assessment of the need for tube feeding will be in:  30 days  60 days  \_\_\_ days #

**Subsequent assessments will be based on clinical status.**

- Need will be based on the following goals of therapy:
  - returning to baseline level of consciousness
  - weight gain and/or improvement in nutrition
  - regaining ability to swallow
  - other: \_\_\_\_\_
  - prolonging life
  - improving quality of life and/or functional status
  - enabling potentially curative therapy

\_\_\_\_\_  
Physician (Designee) Signature

\_\_\_\_\_  
Physician (Designee) Printed Name

\_\_\_\_\_  
Date

## Benefits and Burdens of PEG Placement

	<b>Dysphagic Stroke</b>  (Patients with previous good quality of life, high functional status <sup>1</sup> and minimal co-morbidities)	<b>Dysphagic Stroke</b>  (Patients with decreased level of consciousness, multiple co-morbidities, poor functional status <sup>1</sup> prior to CVA)	<b>Amyotrophic Lateral Sclerosis (ALS) (Lou Gehrig' s Disease)</b>	<b>Persistent Vegetative State (PVS)</b>	<b>General Frailty</b>  (Patients with multiple co-morbidities, poor functional status, failure to thrive)	<b>Advanced Dementia</b>  (Patients needing help with daily care, having trouble communicating, and/or incontinent)	<b>Advanced Cancer</b>  (Excludes patients with early stage esophageal & oral cancer)	<b>Advanced Organ Failure</b>  (Patients with CHF, renal or liver failure, COPD, anorexia-cachexia syndrome)
<b>Prolongs Life</b>	<i>Likely</i>	<i>Likely in the short term</i>  <i>Not likely in the long term</i>	<i>Likely</i>	<i>Likely</i>	Not Likely	Not Likely <sup>2</sup>	Not Likely	Not Likely
<b>Improves Quality of Life and/or Functional Status</b>	up to 25% regain swallowing capabilities	Not Likely	Uncertain	Not Likely	Not Likely	Not Likely	Not Likely	Not Likely
<b>Enables Potentially Curative Therapy/Reverses the Disease Process</b>	Not Likely	Not Likely	Not Likely	Not Likely	Not Likely	Not Likely	Not Likely	Not Likely

### **Benefits of PEG placement rather than feeding orally:**

- For dysphagic stroke patients in previous good health, patients with ALS, and patients in a persistent vegetative state, may prolong life
- For dysphagic stroke patients in poor health previously, may prolong life in the short-term (days to weeks).
- Enables family members/caregivers to maintain hope for future improvement
- Enables family members/caregivers to avoid guilt/conflict associated with choosing other treatment options
- Allows family/caregivers additional time to adjust to possibility of impending death

### **Burdens of PEG placement rather than feeding orally:**

- 75% of stroke patients previously in good health not likely to have improved quality of life and/or functional status
- PVS patients not likely to have improved quality of life and/or functional status
- Possible patient agitation resulting in use of restraints
- Risk of aspiration pneumonia is the same or greater than that of patient being handfed
- Stroke patients previously in poor health, frail patients and patients w/ advanced dementia, cancer or organ failure have been reported to experience side effects: PEG site irritation or leaking (21%), diarrhea (22%), nausea (13%) and vomiting (20%)<sup>3</sup>

### **Benefits of feeding orally rather than inserting a PEG:**

- Patient able to enjoy the taste of food
- Patient has greater opportunity for social interaction
- Patient's wishes and circumstances can be taken into consideration as pertains to pace, timing and volume of feeding

### **Burdens of feeding orally rather than inserting a PEG:**

- Requires longer period of time to feed a patient
- Patient/family worry about "not doing everything in their power" to address the feeding problem and/or "starving patient"
- Patient/family feel that in not choosing option that could possibly prolong life, they are hastening death

**This information is based predominately on a consensus of current expert opinion. It is not exhaustive. There are always patients who prove exceptions to the rule.**

1. Functional Status refers to Activities of Daily Living. A poor functional status means full or partial dependency in bathing, dressing, toileting, feeding, ambulation, or transfers.

2. There is a small group of patients who fall into this category whose life could be prolonged.

3. Callahan CM, Haag KM, Weinberger M, Tierney WM, Buchanan NN, Stump TE, Nisi R. Outcomes of Percutaneous Endoscopic Gastrostomy among Older Adults in a Community Setting." *J Am Geriatr Soc.* 2000 Sep; 48(9):1048-54.

# Legal and Ethical Issues Related to PEGs

## Legal Requirements for Withholding or Withdrawing Tube Feeding:

**For patients/residents with capacity**, the usual standards of informed consent (or refusal) apply.

**For patients/residents without capacity**, the challenge is to make the decision according to the individual's wishes, or if not known, in the individual's best interest. Mechanisms to do this include:

- A health care “agent,” as properly appointed on a health care proxy form when the individual had capacity, is legally empowered to make decisions regarding withholding or withdrawing tube feeding based on “reasonable knowledge” of the individual's wishes. One way to achieve this is for the Health Care Proxy form to indicate that the Health Care Agent “knows my wishes, including those regarding artificial hydration and nutrition”.
- If there is **no formally designated health care agent**, the legal standard for withholding or withdrawing a feeding tube is “**clear and convincing evidence**” of the patient's wishes. A **prior written statement** about feeding tubes or artificial nutrition in a Living Will, or clear **prior oral statements** by the patient about his or her wishes provides “clear and convincing evidence”.
- Such “**clear and convincing evidence**” may be provided by **family members, close friends**, health care professionals, caregivers, or **others** who have had close contact with the individual.
- **MOLST can be used now ANYWHERE in New York State** to provide “clear and convincing evidence” of a patient's wishes regarding withholding or withdrawing life-sustaining treatment, including tube feeding, provided the section addressing these issues is completed in advance, after discussions with the patient's physician.

**If there is no health care agent and no clear and convincing evidence** of an individual's wishes, **consider** obtaining a **legal guardian** with the power to make medical decisions, including those regarding withholding or withdrawing life-sustaining treatment, on the individual's behalf.

## In discussions with patients/residents and families:

### **Focus on the patient's own values, preferences and beliefs:**

- Focus on the underlying disease process as cause of decline and loss of appetite.
- Emphasize the active nature of providing comfort care.
- Recognize the concerns about “starvation”, inadequate nutrition or hydration and potentially hastening death that many individuals deal with in facing this decision and address these issues.
- Clarify that withholding or withdrawing artificial nutrition and hydration is NOT the same as denying food and drink.

### **Understand cultural and religious values:**

- Most cultures and religions recognize death as a normal aspect of life. Most allow for weighing the benefits and burdens of medical treatment including tube feeding.
- Explore religious and cultural values that might influence the decision about tube feeding.
- When in doubt or unfamiliar about a patient's/resident's belief system, consult with a chaplain or spiritual leader from their own tradition if possible.
- Recognize how one's own religious or spiritual feelings affect how tube feeding is discussed with patients/residents and their families, and attempt to minimize the influence these factors might have on the decision-making process.

12.07.07

# Patient Information on Benefits and Burdens of PEGs

## GOALS OF CARE

**D I S E A S E S**

		<b>Improves Quality of Life or Functional<sup>3</sup> Ability</b>	<b>Enables a Cure or Reverses the Disease Process</b>
	<b>Prolongs Life</b>		
Stroke (good health in general before this)	Likely	Up to 25% regain ability to swallow	Not Likely
Stroke (in poor health before this)	Likely in the short term	Not Likely	Not Likely
	Not likely in the long term		
ALS Lou Gehrig's Disease <sup>1</sup>	Likely	Uncertain	Not Likely
Persistent Vegetative State <sup>2</sup>	Likely	Not Likely	Not Likely
Advanced Organ Failure	Not Likely	Not Likely	Not Likely
General Frailty	Not Likely	Not Likely	Not Likely
Advanced Dementia	Not Likely <sup>4</sup>	Not Likely	Not Likely
Advanced Cancer	Not Likely	Not Likely	Not Likely

This information is based predominately on a consensus of current expert opinion. It is not exhaustive. There are always patients who prove exceptions to the rule.

1. A severe disease affecting the brain and spinal cord
2. Person with severe brain damage with no awareness
3. Ability to do things like eating, dressing, going to the bathroom without assistance
4. There is a small group of patients who fall into this category whose life could be extended

## Patient Information on Benefits and Burdens of PEGs

### Benefits of having a feeding tube (PEG) rather than feeding by mouth:

- Family members/caregivers avoid guilt and conflict associated with choosing other treatment options
- Family members/caregivers given additional time to adjust to possibility of impending death
- Family members/caregivers can maintain hope for future improvement

### Benefits of feeding by mouth rather than through a feeding tube (PEG):

- Patient able to enjoy taste of food
- Patient has greater opportunity for social interaction
- Patient's wishes and circumstances taken into account in terms of pace, timing and volume of feeding

### Burdens of having a PEG rather than feeding by mouth:

- PEG patients may become restless and need to be restrained
- Patients with PEG tubes may have the following symptoms, some of which may be caused by the tube (diarrhea, vomiting) and some made worse by the tube (skin breakdown from diarrhea, lung congestion, aspiration pneumonia)

### Burdens of feeding by mouth rather than having a PEG:

- Feeding a patient by mouth requires a longer period of time
- Patient/family worry about "not doing everything in their power" to address the feeding problems and/or "starving the patient"
- For certain stroke, ALS, and PVS patients, family/caregivers feel in not choosing an option that can extend life, they are hastening death

*Risk of getting aspiration pneumonia, pneumonia due to having saliva or food go into your lungs when breathing, is same or greater for the PEG patient than the handfed patient.*

This information is based predominately on a consensus of current expert opinion. It is not exhaustive. There are always patients who provide exceptions to the rule.

# Questions to Consider When Making A Decision About PEGs/Tube Feeding\*

## What is your family member's situation?

- is the underlying condition causing the eating problem likely to get better?
- is the feeding tube needed to help provide nutrition?
- how concerned are you about specific complications of the feeding tube (such as minor or major tube problems, bleeding, infections)?
- is the patient likely to become agitated with the tube and need to be restrained to keep it in?
- will feeding tube placement make a difference as to where the patient can live?
- is the patient aspirating, inhaling material into his/her lungs?
- does the patient have any of the factors associated with decreased chances of survival?
- how will the feeding tube affect the person's quality of life?

## What would your family member want?

- has s/he ever expressed her wishes (in a living will or previous discussion) about the use of medical technologies like feeding tubes?
- what are his/her beliefs and values about end-of-life care?
- if s/he could weigh the advantages and disadvantages, what do you think s/he would choose?
- what do you feel is in your family member's best interests?

## How the decision is affecting you:

- are you having feelings of guilt?
- are you feeling pressure from others?
- is there any conflict between your personal beliefs and those of the patient?
- do you worry about the future decisions regarding continuing with the tube?

## What questions need answering before you can decide?

## Who should decide about placing the tube?

## What is my overall "leaning" about placing a feeding tube?

\*Excerpted from Making Choices: Long Term Feeding Tube Placement in Elderly Patients by Mitchell, Tetroe and O'Connor

## **To Help You Make A Decision About Tube Feeding<sup>1</sup>**

Before they are seriously ill or approaching death, some individuals have completed a health care proxy and living will, and discussed their wishes at great length with a health care spokesperson. In these cases, the health care spokesperson may have a clear understanding of the person's preferences regarding tube feeding. However, in many cases the patient or the health care spokesperson is unclear about what choice to make. At that point, all of the benefits and burdens of tube feeding over eating or drinking by mouth need to be considered so an informed decision can be made.

### **Eating At the End of Life**

In all cultures and throughout all history, offering food has been a sign of caring and hospitality. Our mothers made sure we were well fed. Most people enjoy eating with family and friends, especially on special occasions. In most religions, food is part of sacred rituals. It is no wonder, then, when someone we love is unable to eat and drink naturally, that we feel compelled to "feed" them in some way. It seems to be basic caring.

But, as death approaches, you will not "keep up your strength" by forcing yourself to eat when it makes you uncomfortable. If eating is a social event for you, or providing food is one of the common ways of expressing caring in your family, your loss of appetite may be distressing to you and your loved ones. You might enjoy small amounts of home-cooked food, dishes that mean something special to you. However, you should also know that a decrease in appetite is natural and eating less may increase, rather than decrease, comfort.

Because most dying people are more comfortable without eating or drinking near the end of life, giving food or liquids to them by tube feeding is usually not beneficial, especially if restraints (a tool that limits movement), IVs (used to supply fluids into your veins), or hospitalization are required.

The truth is, for those who are dying, the time comes when it might be more compassionate, caring, even natural, to allow a natural dehydration (loss of body water) to occur. Tube feeding and providing fluid through an IV can make the last days of their lives more uncomfortable.

### **Tube Feeding for the Stroke Patient**

Sometimes people who suffer a stroke cannot swallow at first and a tube is inserted to provide nutrition (food) and hydration (liquid). Sometimes these patients can learn to eat again, and the tube is eventually removed. Sometimes a patient with throat cancer might not be able to swallow after successful treatment of the disease. He or she may have a feeding tube and still carry on otherwise normal activities. Few would question whether feeding tubes are appropriate in cases like these. But there are cases where feeding tubes and IVs are more of a burden to the patient than a benefit.

## **A Trial of Tube Feeding**

Tube feeding, taking in food and liquids artificially, can be done for a period of time and then stopped.

If death is not expected in hours to days, you and your family may consider a time-limited trial of artificial food or liquid to see if it improves comfort, alertness, or energy. To give tube feedings for a short period of time, a tube is usually threaded through the nose into the stomach. For longer periods of tube feedings, tubes (called PEGs) may be placed through the abdomen directly into the stomach. A PEG tube may be placed in a patient by a gastroenterologist (stomach doctor) or surgeon, depending on the patient's other medical problems. Intravenous (IV) catheters, a different type of a thin hollow tube, are usually placed in the veins of the arm or hand to provide liquids. If IVs are going to be used for food as well as liquids, then larger IVs usually must be placed in the large veins of the arm, neck, chest, or groin (area where the thigh meets the hip).

You and your family should agree in advance with your doctor about what you hope to accomplish from being provided with artificial food or liquids. You should also determine, in advance, how long to wait to see if you are getting any better before removing the tubes.

The evidence from medical research and patients' bedsides suggests that it is often more comfortable to die without artificial liquids provided either by a feeding tube or into the veins. Until this generation, everyone who died a natural death died without artificially supplied fluids. Refusing food and drink has always been a sign of the last phase of serious condition leading to death. Only recently have people been afraid that not providing food and fluid through a tube would force someone to "starve to death." There is no medical or clinical evidence that not putting a feeding tube or IV into a person leads to a more painful death. In fact, the research says just the opposite.<sup>2</sup>

Without artificial liquids there tends to occur a loss of body water resulting in a dry mouth. Very few people feel any thirst. Dry mouth can be easily addressed with good mouth care, ice chips or a moistened sponge swab.

## **Tube Feeding and the Dementia Patient**

Increased difficulty with eating and swallowing is one of the signs that an Alzheimer's patient has moved into the final stages of the disease. An Alzheimer's patient may tend to choke on food and drink, running the risk of an infection affecting one's breathing. This person may lose interest in food or forget how to swallow. These signs mark the end of a very sad and long disease process. By this point the patient is often totally dependent on others for care, unable to go back and forth to the

bathroom or use a bed pan, unable to recognize family or to speak in a manner that makes sense.

Some may choose to treat the reduction in food and fluid intake with a feeding tube. Family, doctors, or nurses may say they do not want the patient to "starve" to death. Providing tube feeding is certainly an acceptable way to provide care.

However, the patient isn't feeling any hunger. The inability to eat is an expected part of the final stage of a person's life. Inserting a tube will not stop the progression of a fatal disease, though it might affect the length of time it takes for a person to go through the last stages of dying. Since dying without fluid intake is comfortable, many loved ones choose to forgo the tube feeding. Offer the patient whatever he or she can tolerate by spoon feeding and drinking. Sips of water and ice chips can relieve dry mouth. This decision poses the kind of perplexing situation that may become clearer as society has more experience with it.

### **Tube Feeding When the Person is Unconscious**

Many people can be supported with artificial feeding even though they do not seem to be conscious or aware. Some stroke patients may never again respond to what is happening around them. Many young people have suffered a head injury and are also permanently unconscious. Two well-known court cases involved Karen Ann Quinlan and Nancy Cruzan, who both lived for years supported by feeding tubes, though they were never aware of their surroundings. These patients are said to be in a **persistent vegetative state**. Are we obligated to keep such patients alive even though there is no hope of their recovery to a state of awareness? If we do choose to withdraw the tube feeding, would these patients experience a painful death? Would we be killing the patient?

The courts and medical practice have ruled it acceptable to withhold or withdraw tube feedings from such patients. Many faith communities have weighed in on decisions like these as well. The real struggle for the families of these patients is an emotional and spiritual one. If the patient could make his or her own decision, would the choice be to start tube-feeding or not, or to try it on a time-limited basis? What role does the patient's faith play in this decision? Are we making decisions that honor the patient's wishes or *our wishes for the patient*?

1. Adapted from Handbook for Mortals: Guidance for People Facing Serious Illness Joanne Lynn, MD and Joan Harrold, MD: 1999 Oxford University Press.

2. McCann RM, Hall WJ, Groth-Juncker A. "Comfort Care for Terminally Ill Patients: The Appropriate Use of Nutrition and Hydration." Journal of the American Medical Association 1994; 272 (16): 1263-1266.

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