Artificially-Administered Nutrition and Hydration (ANH)

A frequent ethical dilemma in contemporary medical practice is whether or not to employ artificial means to provide nutrition or hydration[1] in certain clinical situations. Legal precedents on this question do not always resolve the ethical dilemma or accord with Christian ethics. CMDA offers the following ethical guidelines to assist Christians in these difficult and often emotionally laden decisions. The following domains must be considered:

BIBLICAL

1. All human beings at every stage of life are made in God's image, and their inherent dignity must be treated with respect (Genesis 1:25-26). This applies in three ways:
    a. All persons or their surrogates should be given the opportunity to make their own medical decisions in as informed a manner as possible. Their unique values must be considered before the medical team gives their recommendations.
    b. The intentional taking of human life is wrong (Genesis 9:5-6; Exodus 20:13).
    c. Christians specifically (Matthew 25:35-40; James 2:15-17), and healthcare professionals in general, have a special obligation to protect the vulnerable.
2. Offering oral food and fluids for all people capable of being safely nourished or comforted by them, and assisting when necessary, is a moral requirement (Matthew 25:31-45).
3. All people are responsible to God for the care of their bodies, and healthcare professionals are responsible to God for the care of their patients. As Christians we understand that our bodies fundamentally belong to God; they are not our own (1 Corinthians 6:20).
4. We are to treat all people as we would want to be treated ourselves (Luke 6:31).
5. Technology should not be used only to prolong the dying process when death is imminent. There is "a time to die" (Ecclesiastes 3:2).
6. Death for a believer will lead to an eternal future in God's presence, where ultimate healing and fulfillment await (2 Corinthians 5:8; John 3:16, 6:40, 11:25-26, and 17:3).
7. Medical decisions must be made prayerfully and carefully. When faced with serious illness, patients may seek consultation with spiritual leaders, recognizing that God is the ultimate healer and source of wisdom (Exodus 15:26; James 1:5, 5:14).
8. Illness often provides a context in which the following biblical principles are in tension:
    a. God sovereignly uses the difficult experiences of life to accomplish his inscrutable purposes (Job; 1 Peter 4:19; Romans 8:28; 2 Corinthians 12:9).
    b. God desires his people to enjoy his gifts and to experience health and rest (Psalm 127:2; Matthew 11:28-29; Hebrews 4:11).

MEDICAL

1. Loving patient care should aim to minimize discomfort at the end of life. Dying without ANH need not be painful and in some situations can promote comfort.
    a. Nutrition: In the active stages of dying, as the body systems begin to shut down, the alimentary tract deteriorates to where it cannot process food, and forced feeding can cause discomfort and bloating. As a person can typically live for weeks without food, absence of nutrition in the short term does not equate with causing death.
    b. Hydration: In the otherwise healthy patient with reversible dehydration, deprivation of fluids causes symptoms of discomfort that may include thirst, fatigue, headache, rapid heart rate, agitation, and confusion. By contrast, most natural deaths occur with some degree of dehydration, which serves a purpose in preventing the discomfort of fluid overload. As the heart becomes weaker, if not for progressive dehydration, fluid would back up in the lungs, causing respiratory distress, or elsewhere in the body, causing excessive swelling of the

tissues. In the dying patient, dehydration causes discomfort only if the lips and tongue are allowed to dry.

2. Complications of ANH.
    a. Tube feedings may increase the risk of pneumonia from aspiration of stomach contents.
    b. Tube feedings and medications administered through the tube may cause diarrhea, increasing the possibility of developing skin breakdown or bedsores, and infections, especially in an already debilitated patient.
    c. Patients with feeding tubes will, not infrequently, either willfully or in a state of confusion, pull at the feeding tube, causing damage to the skin at the insertion site or dislodging the tube. Prevention of harm may require otherwise unnecessary physical restraints or sedating medications.
    d. The surgical procedure of inserting a percutaneous gastrostomy (feeding) tube can occasionally lead to bowel perforation or other serious complications.
    e. Complications of TPN include those associated with the central venous catheter, such as blood vessel perforation or collapsed lung; local or blood stream infection; and complications associated with the feeding itself, such as fluid overload, electrolyte disturbances, labile blood glucose, liver dysfunction, or gall bladder disease.
3. Disease context
    a. Cancer: End stage cancer often increases the metabolic requirements of the body beyond the nutrition attainable by oral means. When the cancer has progressed to this stage, the patient may experience considerable pain, and ANH may only prolong dying.
    b. Severe neurologic impairment: This frequently has an indeterminate prognosis rendering decision-making problematic. It requires a careful evaluation of the probability of improvement, the burdens and benefits of medical intervention, and a judgment of how much the patient can endure while awaiting the hoped-for improvement.
    c. Dementia: If a patient survives to the late stages of dementia, the ability to swallow food and fluids by mouth may be impaired or lost. ANH has been shown in rigorous scientific studies to improve neither comfort nor the length of life and may, in fact, shorten it (see Appendix).

ETHICAL

1. There is no ethical distinction between withdrawing and withholding ANH. However, the psychological impact may be different if withdrawal or withholding is perceived to have been the cause of death.
2. If there is uncertainty about the wisdom of employing ANH, a time-limited trial may be considered.
3. Any medical intervention should be undertaken only after a careful assessment of the expected benefit vs. the potential burden.
4. The decision whether to implement or withdraw ANH is based on a consideration of medical circumstances, values, and expertise, and involves the patient or designated surrogate in partnership with the healthcare team.
5. It is best that all stakeholders strive for consensus.

SOCIAL

1. Eating is a social function. Even for compromised patients unable to feed themselves, being fed by others provides some of the best opportunities they have for meaningful human contact and pleasure.
2. People suffering from advanced dementia frequently remain sentient and social.

CMDA endorses ethical guidelines in four categories

1. **Strong indications**: Situations where the use of ANH is strongly indicated and it would be unethical for a medical team to decline to recommend it or deny its implementation. Examples of these situations would be:

a. A patient with inability to take oral fluids and nutrition for anatomic or functional reasons with a high probability of reversing in a timely manner.
b. A patient who is in a stable condition with a disease that is not deemed to be progressive or terminal and the patient or surrogate desires life prolongation (e.g., an individual born unable to swallow but who is otherwise viable, or the victim of trauma or cancer who has had curative surgery but cannot take oral feedings).
c. A patient with a newly-diagnosed but not imminently fatal severe brain impairment in the absence of other life-threatening comorbidities.
d. Gastrointestinal tract failure or the medical need for total bowel rest may justify the use of TPN in some contexts not otherwise terminal.
e. An otherwise terminal patient who requests short term ANH, fully informed of the risk being taken, to allow him or her to experience an important life event.

2. **Allowable indications**: Situations where the use of ANH is morally neutral and the patient or surrogate should be encouraged to make the best decision possible after the medical team has provided as much education as necessary. Examples of these situations would be:
   a. A patient with severe, progressive neurologic impairment who otherwise desires that life be prolonged (e.g., end-stage amyotrophic lateral sclerosis).
   b. Conditions that would not be terminal if ANH were provided but, in the opinion of either the patient or surrogate, there is uncertainty whether the anticipated benefits versus burdens justify the intervention.
3. **Not recommended but allowable**: Situations where the use of ANH may not be recommended in all instances but, depending on the clinical context, would be morally licit, assuming the patient or surrogate has been informed of the benefits and potential complications and requests that it be initiated or continued. Examples of these situations would be:
   a. A patient who has a disease state, such as a major neurologic disability, where, after several months of support and observation, the prognosis for recovery of consciousness or communication remains poor or indeterminate. In cases where ANH is withdrawn or withheld, oral fluids should still be offered to the patient who expresses thirst.
   b. A patient whose surrogate requests overruling the patient's advance directive and medical team's recommendation against ANH because of the particular or changing clinical context.
   c. Placement of a PEG in a patient who is able but compromised in the ability to take oral feeding as a convenient substitute for the sometimes time-consuming process of oral feeding, for ease of medication administration, or to satisfy eligibility criteria for transfer from an acute care setting to an appropriate level of short-term nursing care, long-term care, or a rehabilitation facility. ANH decisions in such cases should consider the potential benefits versus risks and burdens of available feeding options, the capacity of caregivers to administer feedings, and prudent stewardship of medical and financial resources, always in regard to the best interest of the patient.
4. **Unallowable indications**: Situations where it is unethical to employ ANH. Examples of these situations would include:
   a. Using ANH in a patient against the patient's or surrogate's expressed wishes, either extemporaneously or as indicated in an advance directive and agreed to by the surrogate. There may be particular medical contexts in which a surrogate may overrule an advance directive that requests ANH on the basis of substituted judgment if the surrogate knows the patient would not want it in the present context.
   b. Compelling a medical professional to be involved in the insertion of a feeding tube or access for TPN in violation of his or her conscience. In this situation the requesting medical professional must be willing to transfer the care of the patient to another who will provide the service. (See CMDA statement on Healthcare Right of Conscience)

c. Using ANH in a situation where it is biologically futile, as in a patient declared to be brain dead. An exception would be the brain dead pregnant patient in which the purpose of ANH is to preserve viable fetal life; ANH in this circumstance is not futile for the life in the womb.
d. Using ANH in an attempt to delay the death of an imminently dying patient (except in the context in 1.e. above).

CMDA recognizes that ANH is a controversial issue with indistinct moral boundaries. Disagreements should be handled in the spirit of Christian love, showing respect to all.

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[1] ANH may be given enterically through a nasogastric (NG) tube. Alternatively, a percutaneous gastrostomy tube (PEG) may be inserted endoscopically so that a feeding tube is passed through the abdominal wall. Total parenteral nutrition (TPN) is administered through a large bore catheter inserted into a central vein in the chest. Hydration (water plus electrolytes) may be given with nutrition in any of these ways or alone through a peripheral intravenous catheter or, less commonly, through a catheter inserted subcutaneously.