The question of whether to insert a feeding tube is one of the most difficult issues in the management of severely ill patients. We cannot expect a simple answer to this quandary. Within the spectrum of confessing Christians, there is no consensus on this matter. In addition to the variance of opinion across believers, individuals may be conflicted internally about blanket ‘yes, no?’ pronouncements with respect to feeding tubes.

Most clinicians would recommend tube feeding when there is a reversible process that temporarily prevents oral feeding, such as after esophageal surgery. Similarly, there are very few who would recommend tube feeding when the patient cannot eat because of an esophageal blockage caused by an untreatable cancer. This spectrum of conditions forces the question of where to draw the line.

In an effort to clarify decisions regarding feeding tubes, I present several questions for consideration.

What is the benefit vs. burden of the feeding tube?

Medical decisions are often driven by the benefit of an intervention compared to its burden. What makes tube feeding unique is that the benefit may be huge while the burden is typically small.

Benefits of feeding tubes:

A feeding tube may allow life to be prolonged for decades in an otherwise healthy individual. While food and water are essential to life, there is considerable controversy in the medical literature as to how much artificial nutrition and hydration help at the time of death. It appears that, for some, starvation and dehydration are rather uncomfortable and provision of food and fluids contribute to comfort. This is not true for all (e.g., comatose patients).

Food and fluid have a definite symbolic role; they imply care. It is satisfying to know that we are meeting the needs of our loved ones. Choosing not to provide food and fluid can be distressing. Right and wrong, however, are not determined by ‘our feelings’ or the ‘symbolic’ value of the feeding tube. We do not seem to struggle in the same way with providing a respirator to the dying, yet air is of more immediate value than food and water.

One additional benefit of feeding tubes needs to be mentioned in a perverse sense. Feeding tubes are relatively easy. It is at times very difficult and time consuming to hand-feed a patient who is able to swallow but unable to
feed herself. A feeding tube may be an easy way out, but this is not acceptable. Some of these dear souls are relatively cut off from human touch and care. The only caring they may receive is at meal time. They should not be deprived of this for the convenience of a feeding tube.

Burdens of feeding tubes:
The burdens of a feeding tube include the minor discomfort of its insertion and diarrhea that is often caused by tube feeding. In a debilitated patient who is not able to get prompt nursing care, diarrhea may increase the incidence of skin break down or bedsores. The patient may also experience infection or skin irritation at the site of the feeding tube insertion. If the feeding tube is inserted through the nose, there is a high incidence of aspiration where stomach contents regurgitate up and are sucked into the lungs. The incidence is less, though not absent, when a gastric tube is inserted directly through the abdomen into the stomach.

In considering burden we must realize that many people who die without a feeding tube lapse into coma fairly quickly and are unaware of any physical discomfort. Many are not conscious of hunger or thirst. Feeding tubes have the potential to preserve the patient’s level of consciousness and thus prolong the agony of the underlying disease or of the dying process. This may be considerably more painful than any discomfort associated with starvation and dehydration. What discomfort there is can readily be handled by techniques to moisten the mouth and by using appropriate amounts of analgesics, such as morphine, administered under the tongue. At the end of life, as the body begins to shut down, it is common for the heart to get weaker. If abundant fluid is given to the patient by a feeding tube, congestive heart failure may result if the lungs fill with fluid and cause a distressing shortness of breath.

The benefit-burden equation will vary significantly from one patient to another and must always be answered on a case-by-case basis.

What is the purpose of the feeding tube?
Is it intended as treatment to allow for restoration of normal function?
Is it to delay death?
Is it to prolong life?

When the underlying cause of the inability to swallow is thought to be reversible, the feeding tube is used as a treatment. At some times the problem will be caused by surgery or by a stroke and recovery is expected. At other times it may simply be an expression of the patient’s weakness. In that scenario, a key way to gain strength is to provide adequate nutrition. There will be times, however, when a feeding tube intended to be treatment proves ineffective. By default it becomes an intervention to prolong life or to delay death.

Anticipating that situation, it may be wise at the time of insertion to put a time limit on it. For example, Grandma had a major stroke at 97, she is too weak to swallow, and without a feeding tube she will only get weaker. She has often said that she does not want to die ?hooked to a machine.? Nevertheless, it may be appropriate to insert a feeding tube, hoping that perhaps within three months she will be stronger and able to swallow on her own. In three months, if she is not able to do that, we want to honor her wishes and discontinue the feeding tube.

If the feeding tube is used in a patient who has a progressive terminal illness the tube may only delay death and the use of a feeding tube may simply prolong or increase the agony. The operative words are ?progressive terminal illness,? which would include such conditions as cancer; kidney, heart, or lung failure. It would also include dementia and advanced age. It does not include someone who is stable though disabled after a brain injury or stroke. In the context of progressive terminal illness it can be argued that tube feeding should generally not be done. When the patient dies the ultimate cause of death is the underlying disease, not starvation or dehydration.
In the absence of a progressive terminal disease, the feeding tube may be used to prolong life. Since the patient is not dying of another cause, discontinuing the feeding tube would imply a desire to cause the patient’s death. It is in this context that most of the controversy occurs.

If the patient is able to express her views now, or in the past has clearly expressed her desires on this issue, they should be heeded. All too frequently, however, a statement is made in very categorical terms whether or not to use a feeding tube. It would be wiser, rather than saying yes or no, to discuss the context in which they would not want a feeding tube and allow for situations where they would be willing to have one.

If there is not a clear understanding of the patient’s wishes in the particular situation, the decision falls to the designated power of attorney for health care or whoever is in the decision-making role. Few of us would choose to be severely disabled and we would not want that for our loved ones. Yet, as Christians, we do not consider the lives of the severely disabled meaningless. They are made in the image of a God who loves them and is working for the good. The love that we show them may demonstrate the love of God to a watching world.

The difficult situation lies with the patient who is mentally incompetent, has not left clear instructions, and is dependent on the feeding tube to live. The tension for the Christian is to choose whether to emphasize the value of life and the fact that death is an enemy to be avoided, versus affirming the Gospel and seeing death as a defeated enemy by Christ’s own death and resurrection.

Life is not ultimately about our comfort or about our desires but rather about God and his glory. Decisions by doctors, patients, and family about feeding tubes must be made with an eye to God and his glory rather than with a primary focus on ourselves and our comfort.

Do we consider feeding tubes ordinary? or extraordinary? care?
This is the key question in the minds of many. It may boil down to the trite ?What would Jesus Do?? in a very non-trite sense. If we view feeding tubes as ordinary, they fall within the purview of Matthew 25:35-40 where Jesus commends those who feed the hungry and give drink to the thirsty, even though they are ?the least of these.? It is certainly expected that we give food and nutrition to the needy. The question is, ?are we expected to use feeding tubes??

Perhaps a distinction better than ?ordinary? versus ?extraordinary? is the concept of proportionate versus disproportionate care, which was introduced by Pope John Paul II in his Evangelium Vitae of 1995. This moves the decision from the blanket ?yes, no? response into the realm of ?maybe.? In other words, it makes the decision context-dependent. It allows for the application of the law that Christians are under: ?the law of the spirit of life in Christ Jesus? (Romans 8:2). As believers, we are not free to do anything we want; rather we are freed from the forces that have kept us from doing what is right.

The choice of whether to use a feeding tube is a solemn matter. In many cases, it is a life and death decision. While we have no explicit guidelines in Scripture, our response is not inconsequential. We must make it carefully and prayerfully. We must seek the counsel of our loved ones and spiritual leaders. Most importantly, we must seek the guidance of God’s Spirit with a passion for God’s glory. Finally, we must recognize the uniqueness of each case. In some, God will lead one direction and in others He will lead differently. We should be slow to criticize.

This work is licensed under a Creative Commons Attribution-NonCommercial-NoDerivs 3.0 United States License.

Source URL (retrieved on 11/02/2017 - 04:19): https://cbhd.org/content/feeding-tube-dilemma-key-questions