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Doctors

Food and the Dying Patient

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The patient had dementia and could no longer swallow. The intricate workings of the muscles of her throat were failing, and she was no longer able to move food or liquids reliably into her stomach. Instead, they too frequently ended up in her lungs, and she drowned a little more with every swallow. She was admitted to my intensive care service with pneumonia from aspirated food that had turned the bottom part of her left lung into a wet sponge. Her blood oxygen levels had dropped so low that we had to support her breathing by inserting a tube.

Now, after she was on powerful antibiotics and life support for three days, her oxygen level had improved and her fevers had abated. She was getting better, in a manner of speaking.

This pneumonia was her third, and easily her worst, in four months. This pattern is typical of end-stage dementia, when patients lose control of their swallowing mechanism and often die from the pneumonias that result from food lodging in the lung. Usually, these patients have gone in and out of the hospital through a sort of revolving door; as soon as one pneumonia is chased away by antibiotics, another emerges.

Our medical system deals well with organ dysfunction. When a kidney isn't working, we can clean blood with a dialysis machine. When a person can't breathe, we can push air into the lungs. And if there is trouble swallowing, we can bypass the throat with a feeding tube that goes through the abdominal wall directly into the stomach.

That last option had been offered to this patient's family when she was admitted to the emergency room. "If she makes it through this, she could get a feeding tube so that this doesn't happen again," they were told. And so now that she was improving, her family was asking for the tube.

But contrary to popular belief, a feeding tube does not prolong life in a patient with dementia. It actually increases suffering. A stomach full of mechanically pumped artificial calories puts pressure on an already fragile digestive system, increasing the chance of pushing stomach contents up into the lungs. And surgically implanted tubes are a setup for complications: dislodgments, bleeding and infections that can result in pain, hospital admissions and the use of arm restraints in already confused patients. But maybe most important, the medicalization of food deprives the dying of some of the last remnants of the human experience: taste, smell, touch and connection to loved ones.

So why do so many demented patients die with feeding tubes?

Food is how we know best to care for one another, from breast to deathbed. And thus it runs contrary to every impulse we have as humans to stop feedings. As a dying person becomes unable to process food on her own, our tendency is to plug life into her with a tube pumping artificial nutrition.

Since the beginning of time, humans have fed their dying by hand. Spooned slowly so as not to overwhelm, a trickle of broth or a favorite food ground up to taste may be the last small pleasures for a dying body.

But hand feeding has increasingly become a quaint piece of human history. We fed until they would take no more, and knew that we had done everything we could. But with the feeding tube, we can, and feel we must, keep going. Patients frequently die with plastic tubes weaving mysteriously under their gowns, entering bodies at unnatural angles, rendering them a little more alien to us. Those who are most needed sit a little further away from the bed, afraid to dislodge tubes that are supposedly keeping their loved one alive. And the patient's mouth will usually remain dry and empty until the end.

My last conversation about the patient's feeding took place on my way to my

car Friday afternoon. The patient's sister was walking in as I was walking out. She thanked me for the care I'd provided and told me they had decided to go with the tube. "I couldn't not feed her," she said. "I can't leave her starving."

The next day, my patient was wheeled down to the operating room for her feeding tube, then a few hours later wheeled back to intensive care. Over the next couple of weeks, her sister sat on a chair beside her most days, wearing the requisite paper gown and gloves for guests of patients with resistant bacteria from prolonged hospital stays. She sat off to the side, separated from her sister by tubes, bedrails and the bustle of activity around them.

But the patient never went home to her sister and their beloved soap operas. She died two weeks later in the intensive care unit, a different pneumonia in her lungs.

In the face of death, food and hope are highly seductive. But once again, I was left wondering: Does our need to feed our dying loved ones blind us to what's really best for them?

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