Enteral Feeding Tubes in End-Stage Dementia Patients: To Insert or not to Insert? Administrative and Financial Aspects

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In this issue of IMAJ, Leibovitz et al. [1] present yet another problem with the long-term use of nasogastric feeding tubes in the frail elderly. But a more fundamental question arises: do the present Ministry of Health guidelines for tube use in such patients make any sense at all? In the Israeli context, for historical reasons beyond the scope of this paper, the two forms of enteral feeding are perched on opposite sides of a Great Divide that separates the jurisdiction of the Ministry of Health from that of the four health management organizations. In order to fully understand the present situation in Israel, one needs to be clear as to the definitions of patients deemed either as “nursing” (sigudi in Hebrew) or “complex nursing” (sigudi murcan) [2].

As defined by the Health Ministry, “nursing” patients must meet the following requirements:

“A person with poor health and functional status as a result of chronic disease or a physical or mental deficit, and who suffers from ongoing medical problems requiring professional follow-up and that cause any of the following:

- bedfast or confined to a wheelchair
- single or double incontinence
- serious gait disorder resulting from various diseases.”

In 2003, there were approximately 19,000 beds licensed for the care of such patients in Israel [3–5]. Like the Canadian and British systems, Israel’s National Health Insurance Law covers payment for acute and rehabilitation care for all ages. However, should a patient require long-term institutional care, the Israeli system of subsidies (kadim in Hebrew) is more analogous to the American Medicaid system. Here, the patient/family (in Israel including both spouse and children) must “spend down” in order to become eligible for such support [3,4]. Unlike the situation in Israel, where “complex nursing” patients are included in the Ministry of Health’s approved basket of services and can cost the family up to 9,000 shekels per month (US$ 2,045; US$ 1 = 4.4 NIS).

Although patients belonging to either long-term category may be considered for enteral feeding, only percutaneous enteralgastric tube use is allowed for “nursing” patients. Should a nasogastric tube be utilized (even if the patient exhibits no other change in medical status), the patient jumps to the higher category of “complex nursing.” These patients, for whom there are approximately 1,000 beds, must meet the criteria for “nursing patients” plus any one of the following:

- pressure sore, stage II – IV
- use of an NG tube for long-term feeding
- disseminated carcinoma requiring enteral and parenteral palliative care using opiates
- continuous intravenous therapy
- on dialysis.

The situation in Israel

There are many problems, both clinical and administrative/financial, with the present situation. To begin with the clinical, many would challenge the ethics of such an intervention (either NG or PEG) in the care of an end-stage dementia patient, where enteral feeding is usually deemed futile [6]. Space does not allow us to go into the reasons for the very high rate of tube use in Israel compared to other western countries [7]. However, when such therapy is used, most authorities hold that for the patient there is no significant medical advantage of either technique, with each offering a similar risk-benefit equation. That being said, most clinicians would still favor PEG for aesthetic reasons and because it does not impede the patients’ ability to talk or swallow. The question then arises why these feeding methods should be used to distinguish between different levels of care (i.e., “nursing” vs. “complex nursing”), especially since both techniques require similar amounts of nursing care. In a recent survey in which 10 senior geriatric nurses and 10 senior geriatricians in Israel were asked to grade the “heaviness” of various aspects of nursing care, almost all gave both NG and PEG an identical score of 4/4, judging the burden of care of both techniques to be identical [8].

From the administrative point of view, the present situation in many ways exacerbates the ongoing struggle between the HMOs and the Health Ministry. For example, given that a “nursing” patient is transferred to the “complex nursing” category simply by the act of having an NG tube inserted (or reverts to “nursing” status when it is removed), there exist perverse incen-

NG = nasogastric
PEG = percutaneous enteralgastric
HMO = health management organization
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Quo vadis?

The present illogical situation provides multiple perverse incentives for both the HMOs and the Ministry of Health (as well as the Treasury) to ignore the real clinical needs of chronically ill elderly patients when classifying the level of nursing care required. Patients and their families, if they can understand the rules, realize the absurdity and unfairness of the present situation and understandably balk at following them. It also encourages “illegal” behavior by many long-term institutions and leads to a waste of time and energy on the part of the regulating staff of the Ministry in an attempt to enforce ludicrous and illogical regulations.

Of interest is the fact that published specific recommendations on how to deal with this unfortunate situation were offered by a very sensible set of guidelines published by the Israel Medical Association [13]. They can be briefly summarized as follows:

- Provide clear, ethically sensitive guidelines for the use of enteral feeding technologies for the end-stage dementia patient. Given the universally dismal clinical prognosis of such patients, a palliative as opposed to an active approach is usually indicated. Tube feeding is not always indicated in such patients.
- Where enteral feeding is utilized, allow only the clinical considerations to determine which technique is preferred. In most cases, given the similar risk-benefit equation and increased comfort and aesthetics of PEG over NG, the former technique would normally be chosen.
- Neither PEG nor NG should artificially be placed on either side of the “nursing” and “complex nursing” definitions, nor should the choice of feeding method be used (alone) to determine patient status.
- A redrawing of the definitions of the levels of long-term institutional care should be considered and investigated in the direction of the work initiated by Dworkatzky [8]. In designing these scales, the use of NG and PEG would be given equal weight.
- The NHI law should be fully implemented, as originally planned, to include long-term institutional care within the basket of services [10–12]. This step will, among other things, reduce the perverse incentives relating to the use and abuse of enteral feeding and increase the quality of clinical care for Israel’s frail and terminally ill elderly.

Israel’s frail, demented elderly, especially those in long-term care, deserve a better deal. They are already sick and have lost not only their homes but their independence as well. It is tragic that in a matter as basic as feeding, so many suffer from an administrative quagmire that honors no one and provides so little comfort – to both patients are their families.
References


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A model for T cell recognition

T cells represent a distinct lineage of T cells that undertake a range of specific immune functions. However, compared with their T cell counterparts, the mode of antigen recognition by these T cells is still relatively poorly understood. By resolving a 3.4 angstrom structure of the complex between a specific mouse T cell receptor (TCR) and its non-classical class I major histocompatibility complex ligand, Adams et al. (Science 2005;308:227) have generated a new model of T cell recognition that has features of both innate immune receptor recognition and adaptive recognition through recombination of germline segments. Shin et al. (p. 252) arrived at similar conclusions from a survey of TCR usage at the single-cell level, which led them to suggest that T cells focus on a relatively narrow range of antigenic ligands.

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Prions and mutations

Clinical cases of variant Creutzfeldt-Jakob disease (vCJD), the human counterpart of bovine spongiform encephalopathy (BSE, or mad cow disease), has only been found in individuals homozygous for methionine at polymorphic residue 129 of the prion protein. Primary transmission of BSE or vCJD prions to transgenic mice expressing human PrP valine 129 exhibits a substantial transmission barrier, with a low rate of both clinical prion disease and subclinical prion infection. Wadsworth and associates report that this transmission barrier is not reduced upon second passage in these mice. A valine residue at position 129 of human PrP severely restricts the propagation of both BSE and vCJD prions, and this result suggests that humans of this genotype will be relatively resistant to BSE prion infection. If they do become infected, it will probably be as a result of propagation of a distinct prion strain that results in a disease phenotype distinct from that of vCJD.

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