Long-term nasogastric tube feeding under physical restraint: indications for best practice

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Abstract

Nasogastric tube (NGT) feeding is a common medical intervention used to help malnourished patients meet their nutritional needs. Occasionally this is used to help patients with restrictive eating disorders if they are unable to meet their nutritional requirements through oral diet or supplements when appropriate meal support is given. NGT feeding against a patient's will, requiring physical interventions to maintain their safety, can be used to stabilise a patient medically in lifesaving scenarios. Recent research highlighted the extent of this practice within mental health wards in England, with 622 patients reported to have received this intervention in a one-year period. The length of time for which this intervention was required ranged from a single feed to 17 patients receiving it for over a year, and one patient for six years. These findings have raised ethical and legal concerns regarding the extent of this restrictive intervention and the associated physical, emotional and psychological risks it carries for the patient, as well as the emotional and psychological risk to the inpatient peer group, parents/carers and the staff involved. This paper aims to suggest the best ethical, legal and clinical practice regarding this intervention for those practicing in England and Wales.

Keywords: nasogastric tube feeding, ethical, legal, physical restraint, restrictive practice, best practice

Introduction

Restrictive eating disorders (EDs) can result in malnutrition and this can have detrimental impacts on patient physical health both in the short term, with acute medical instability such as deranged biochemistry, hypothermia and bradycardia, and the long term, with chronic medical problems such as osteoporosis, infertility and dental deterioration. There is guidance available for clinicians to monitor patient physical health (1) and this indicates that a medical admission may be required to save a patient's life or promote medical stability. Most treatment for those with EDs is offered in the community setting (2), with specialist inpatient mental health admissions considered if community treatment has been unsuccessful, refused or is required to contain an emergency.

These admissions are not without challenges, as the nature of EDs is such that the nutrition required is often perceived by the patient as terrifying and distressing. Traditional approaches of offering individualised meal support from highly experienced clinicians, alongside generic meal plans, bespoke meal plans with the patient's safe foods and/or oral nutritional supplements as meal alternatives may not be sufficient for some patients. In these cases, supportive nasogastric tube (NGT) feeding may be considered as this can promote weight gain (3-5) and improve psychological outcomes (6); most patients will be able to understand that this is a necessary short-term medical procedure and consent to it. However, for a few patients, voluntary NGT feeding is refused or sabotaged. If this occurs and their physical health is deteriorating, then NGT feeding against their will may be considered.

Restrictive practices can be defined as "making someone do something they don't want to do or stopping someone doing something they want to do" (7). Restrictive practices are occasionally required to maintain the safety of a patient or other people and should only be implemented if all other, less-restrictive options have not worked, as set out above. It is the treating team's responsibility to hold hope that every patient will be able to eat when the right support is in place, even if they have been unable to do this previously. Ensuring that all patients are given meal support from experienced clinicians alongside food is essential and the least-restrictive option. As NGT feeding under physical restraint is a highly restrictive clinical intervention, it should only be used if all other treatment options have been progressively and sufficiently exhausted as set out above. It may also be appropriate if someone is sabotaging a supportive NGT feed to the extent that their physical health is at risk; examples of sabotage may be from self-induced vomiting or using a hidden syringe to remove feeds once delivered.

Recent research reported the extent of NGT feeding under physical restraint in mental health wards in England. A total of 622 patients received this intervention during 2020, of whom 486 were in child and adolescent mental health

(CAMHS) units, either specialist eating disorder units (SEDUs) or generic units, and 136 were in adult SEDUs (8). This research reported that some patients required just a single NGT feed under physical restraint, whereas 17 patients received this intervention for over a year. The mean duration that this intervention was required for was 29.1 weeks. These data raise both ethical and legal concerns, which will now be discussed in the context of English law, which applies where these data were collected, as there is no doubt that these patients were fed past the point of medical stability.

Clinical considerations

Over the past five years, clinical practice regarding the delivery of NGT feeds when physical restraint is needed has changed significantly. Research suggests that there was a significant range in practice within UK CAMHS mental health inpatient wards. Fifteen percent of CAMHS SEDUs and 27% of generic mental health wards reported using enteral pumps to deliver an NGT feed over an hour or more and some units reported that they would use NGT feeding under restraint up to six times a day (9). This led to a consensus statement, developed using a modified Delphi approach, producing guidance to ensure that this intervention is carried out as safely and quickly as possible in line with least-restrictive practice (10, 11). Specific recommendations with regard to reducing the number of feeds per day, increasing the volume of each feed and delivering via a push syringe bolus rather than enteral pump have reduced the time patients spend in physical restraints for NGT feeds (10). Consequently, patients experience minimal interference with their inpatient treatment and have more time to engage in therapeutic support, education or life skills that support recovery.

Legal considerations

We do not discuss here the frameworks in England and Wales such as the Mental Health Act (MHA) 1983 or the Mental Capacity Act (MCA) 2005 which explain how NGT feeding under restraint can be delivered lawfully. More important, we think, is to take a step back and look at the framework within which those decisions are taken, as this is not always properly understood.

The Human Rights Act 1998, which applies to the whole of the UK, requires clinicians to act in accordance with the obligations imposed by the European Convention on Human Rights (ECHR). The ECHR imposes obligations that are both "positive" and "negative". Positive human rights obligations are obligations to do things, for example, to take appropriate steps to secure the life of a patient at risk of death (to comply with Article 2 of the ECHR). Conversely, negative obligations are obligations not to do things, for example, depriving a patient of their liberty without following a procedure prescribed by law would be a breach of Article 5 of ECHR. It is important that clinicians act in ways that balance these two sets of obligations. One way of thinking of this is to understand that positive obligations explain why clinicians are taking the steps they are taking, whereas the negative obligations exist to ensure that clinicians think through those steps and ensure that there are appropriate checks and balances in place, some of which are described below.

An important question that clinicians should be asking themselves is whether their treatment plan is necessary and proportionate. If proposed treatments are not necessary, for example, if there is no real risk to the patient's life, then it would be very difficult to justify the resulting interference with the patient's rights (for example, to autonomy, under Article 8 of the ECHR). However, even if the proposed treatments might be said to be necessary, it is still vital to ask whether they are in fact proportionate to the gravity of the risk identified, especially given the potential for such treatments to traumatise the patient, their family and, separately, but importantly, the treating team (12).

If a patient is gaining weight, past the point of medical instability, over a period of many weeks or months and sufficient physical health restoration has been secured by means of NGT feeding under physical restraint, the question of whether this practice remains necessary and proportionate must be reconsidered. At this point, it is likely that continued restrictions are no longer proportionate to the risk of deterioration in physical health. Therefore, attempts should be made to wean off physical restraint, moving towards consensual and supportive NGT feeding and then re-establishing an oral diet to manage the risk of deterioration in physical health or weight loss. It is important to note that some clinicians will state that "if we stop feeding and they don't eat, the eating disorder will get stronger" and that, because of this view, NGT feeding under restraint may be maintained appropriately. NGT feeding under restraint should only be continued if it is clinically indicated and not because of the clinician's anxieties around the patient not having adequate nutrition.

Applying the framework above raises, or should raise, concerns when patients are reported to have received NGT feeding under physical restraint for significant periods of time.

Ethical considerations

There are several different ethical principles which need to be balanced when NGT under restraint is considered, especially when it is used past the point of medical stabilisation. Box 1 lists some of these ethical considerations.

In considering the ethical issues of NGT feeding under restraint, it is key that clinicians should not view the situation as a dichotomous, black-and-white decision. Contrary to how some may perceive it, the decision is rarely between high-

Box 1. Ethical considerations in nasogastric tube feeding under physical restraint

- The respect for, and promotion of, patient autonomy and choice, including considering their current and previously expressed wishes, even if they lack the ability to make a decision.
- The overall interests of the patient, balancing potential risks against potential benefits of any treatment option.
- The disruption to everyday life and the enablement of normal maturity, which includes development of identity, independence and emotional regulation.
- The ability of the patient to make treatment decisions, recognising that patients with eating disorders can have subtly impaired abilities to make treatment decisions about the eating disorder even if they are articulate people who remain capable of making other decisions for themselves.
- The balance of the short-term benefits (medical stabilisation) against the long-term harms (risk of traumatisation and enmeshment of illness) of the coercive practice.
- How coercive practice is done and not just whether it is done – the importance of trust and compassion increases as the choice diminishes and the patient experiences increasing coercion.
- The importance of human relationships such as trust, feeling heard and understood, feeling supported, understanding, and knowing in advance when and why coercive treatment is needed.
- The importance of the clinicians surrounding the patient being trusted as experts who can act in the patient's interests so that the patient can feel able to hand control over to them.

ly coercive feeding versus leaving a patient without treatment with the certainty of death. Neither should the decision be made as a single jump from "eating by oneself without the use of compulsory treatment orders" to "NGT feeding under restraint under compulsory treatment orders". There is a hierarchy of levels of pressure/coercion and degree of patient cooperation and assent. Clinicians should always strive to minimise the level, duration and amount of coercion needed and maximise the degree of cooperation and collaboration possible. They need to consider how best to achieve the goals of ensuring patients are safely receiving the nutrition and care they require, while keeping restrictive practices to a minimum in number and degree of aversiveness and traumatic impact.

The degree of coercion and restrictive practice is maximum when a patient needs NGT feeding under restraint. Therefore, the treating team should be working hard with the patient and family to reduce the level of restrictive practice needed and to provide as much choice and autonomy as possible, while appreciating the level of support that patients may need to achieve that. This should be a responsive and dynamic process – a "dance" which takes place within the interface between patient, clinicians and family members – to achieve the best option in the current situation for each individual patient, which will then inevitably change as the situation changes. This is a very individualised treatment plan and should not be based on any general hospital protocol.

Moving towards best practice

The authors propose that best practice could be along the following clinical, ethical and legal principles.

Clinical principles

At times, it is difficult for clinicians to have lengthy conversations with their patient around the need for restrictive practices such as NGT feeding under physical restraint. Some decisions need to be made swiftly to preserve life. However, whenever possible, best practice can be suggested as having these conversations away from the crisis, potentially before admission or at the start (13). Asking the patient if this intervention is required: "What are your wishes? How can we best support you before, during and after this intervention?" This advanced care planning will allow the patient's views to be clearly recorded and will keep them involved in the treatment process. Without this, there is a risk of the patient "giving up" and feeling that treatment is "being done to them" rather than "being done with them".

Ethical principles

It is important for clinicians to find the optimal balance between aiming for the best and longest period of medical stability and minimising the period where restrictive practice is required. Moving the patients towards lower levels of coercion and restrictive practice should be a constant priority, balancing the need for some patients to have extended restrictive practices to establish a physically healthy weight and re-establish normal eating practices, without repeated cycles of rapid weight loss and coercion. At the same time, it is important not to give up on patients – there is a real risk that withdrawal of active treatment and palliative care is being considered for some patients who may yet recover, if only they had experienced the right treatment with trusted clinicians at a time when they were ready to think about, tolerate and embrace recovery.

Legal principles

Clinicians should think clearly about questions of necessity and proportionality first, before jumping to decide whether to use specific frameworks such as mental health or mental capacity legislation. Furthermore, clinicians should be willing to take the patient's case to a clinical ethics committee to elicit a further perspective. If there is still doubt regarding the legal basis of treatment then, as the last resort, clinicians should place the question before the courts

as to whether the balance has been correctly struck, as court orders would provide the correct oversight for the most complicated cases.

Conclusion

This paper has used experts in their field to suggest the best ethical, legal and clinical practice regarding long-term NGT feeding under physical restraint for those practicing in England and Wales. Advanced care planning with patients who are at risk of this intervention at the point of admission allows collaboration away from a physical health crisis and could help to keep patients actively involved in their treatment. Clinical teams should think clearly about questions of necessity and proportionality as they move patients towards lower levels of coercion and restrictive practice.

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