Dear Dr. Jeff:

We have an ongoing concern at our facility on where to draw the line between patient rights and safety, especially with feeding issues. We serve the disabled and have residents with spinal injuries, head injuries, cerebral palsy, etc. Many of these residents have swallowing issues and are at high risk for aspiration. Many also have the competence and the capacity to make decisions. Although we would never want to give a resident on a level 1 diet a level 4 diet due to safety concerns, we do give many a level 2 diet on the grounds of patient rights and quality of life. Another concern is those who request to eat with their doors closed or who want to eat and take medications at less than a 45° incline. I would appreciate your insights into these issues.

Dr. Jeff responds: Your question combines one of the most difficult questions in long-term care medicine with some of the most important but also most difficult questions in medical ethics. Still, it is commendable that you and your facility recognize this is even a problem.

The phrase “at high risk for aspiration” seems clear, but contains a series of traps. First, essentially all human beings are at risk for aspiration. The average adult has an episode of food “going down the wrong way” once or twice a year, and a single episode of food penetrating the upper airway (aspiration) could progress to the feared sequence of aspiration pneumonia or death from airway obstruction (the “café coronary”).

Secondly, most long-term residents meet common criteria for being “at risk,” which include moderate to advanced dementia; history of stroke, Parkinson’s disease, or other neurologic conditions likely to affect upper airway sensory or motor function; history of head and neck cancer; history of pneumonitis in the past year; wet voice; coughing during or after meals; and the use of medications known to decrease swallowing ability or saliva production. Thirty years ago, when the interest in dysphagia was at its zenith, many of these issues were discussed at length in texts and as a basis for research. They were standardized to the patient and his or her needs. For example, alternate feeding positions can be tested, such as varying degrees of bed elevation.

Real-Life Risks

Unfortunately, all the above tests do not reproduce real life. For example, swallowing function may vary with flavor. One article identified significant differences in tongue motor function among water and variously flavored liquids (J Speech Lang Hear Res 2012;55:262-75). Also, foods of similar consistency, particularly those that are part of a regular diet, may represent significantly different risks. Peanuts are particularly dangerous.

I was the medical director of a large facility that annually held a celebration they called a July 4th party, but it should have been called the Heimlich Bowl. Local firemen held a large picnic to honor veterans at which they served beer and hot dogs. The combination of alcohol, soft bread, and a firm round piece of meat is ideal for upper airway obstruction. A good year meant that we rescued everyone without a hospital transfer. Many of the Heimlich survivors were front and center every year. How do you balance the risk of death against the pleasure of the quintessential American event?

Finally, most discussions of swallowing function focus on aspiration as an endpoint. However, a demonstration that food or fluids enter the upper airway is essentially an anatomic concept -- a condition, rather than a disease. Many residents routinely have material enter the trachea but are able to clear it, whether through the post-deglutition cough or via the action of the cilia that beat mucus and trapped materials upward from the lung. These residents may suffer some discomfort from the coughing but will not necessarily go on to aspiration-related bronchitis or pneumonitis. Alternately, the actual volume of material aspirated may be more significant than the simple fact that something entered the upper airway.

The diet levels in your question are from the National Dysphagia Diet, created in 2002 by the American Dietetic Association so that dieters can discuss diet consistencies in similar terms, and as a basis for research. They were never scientifically validated and have not been accepted by the American Speech-Language-Hearing Association as terminology, much less as a basis for clinical treatment guidelines.

Moreover, regardless of prescribed diet consistencies, all residents continuously produce saliva, which is routinely swallowed between meals and at night. Consequently, many programs designed to prevent aspiration pneumonia concentrate on improved oral hygiene, which is definitely a modifiable risk factor, rather than on dysphagia as such. They also modify medication regimens, because antipsychotics and sedatives significantly increase the risk of aspiration pneumonia. Ironically, anticholinergic medications that decrease salivation actually increase pneumonia risk, perhaps because of their adverse effects on cognitive function.

Who Decides What Is Best?

Informed consent occurs when a patient assesses the risks and benefits of a potential action or series of actions. Decision-making capacity is the ability to evaluate these risks and benefits to form and express a rational choice. The risks involved in many choices are relatively trivial, such as which cloth ing to wear, where the worst choice might only produce an unflattering outfit. Many ethicists point to the concept of autonomy as the central principle of modern medical ethics. The right to make decisions for ourselves often trumps other considerations, such as the desire of LTC professionals to provide a safe environment and preserve the health of those under our care. But the real conflict here is not between the concerned caregiver and some legalistic notion of resident rights, but rather between a desire to protect the resident and the need to respect the resident as another human being. It is, essentially, the Golden Rule. This would, in my opinion, extend to choices involving food consistency, the thickness of liquids, the type of food, or the location and position in which food is consumed. Certainly, the resident who is uncomfortable or in frank pain when placed in an “ideal” location, or when the head of his/her bed is raised above a certain level, should be allowed to weigh that negative against the increased risk of aspiration in a preferred position.

Unfortunately, this process becomes more confusing when the professionals have great difficulty quantifying the risks of various swallowing conditions. Similarly, the efficacy of our solutions to these problems seems more conjectural than scientific. Even such well-established maneuvers as chin-tucking have been found in several studies to have limited benefit. Under these circumstances, the preference of the patient should certainly be the deciding factor.

If our own understanding of resident risks and burdens is limited, this suggests that residents have rarely been presented with the details of their dysphagia and the reasoning behind our concerns. Many residents yearn for a different physical condition, which often means that they do not know the full extent of their disability. All too often, residents have simply been told that they have difficulty swallowing or failed a barium swallow with little explanation of what that means. The resident may understand the obvious benefits of their choice without fully understanding the risks.

Unfortunately, in the world of long-term care, there is a never-ending need to document. The reasons behind resident requests for risky behaviors should be explored and addressed. Why would a resident wish to eat in his/her own room with the door closed? Could the desire for privacy be addressed in another way? Does this represent depression, paranoia, or simply embarrassment caused by drooling or use of a bib? Are less risky alternatives available that still meet resident concerns? Or does this represent an effort by a powerless resident to exert some control over their life?

You should certainly document your warnings regarding the nature and

**Share Your Story**

Do you have a story about patient mealtime issues? **Caring for the Ages** will be focusing on aspiration, swallowing, and other feeding concerns in an upcoming issue. Please contact Carey Cowles, managing editor, at c.cowles@elsevier.com for more information.

See Aspiration Risks • page 5
Prescription use of benzodiazepines increases steadily with age, despite the known risks for older people, according to a comprehensive analysis of benzodiazepine prescribing in the United States. Given existing guidelines cautioning health providers about benzodiazepine use among older adults, findings from a recent study raise questions about why so many prescriptions — many for long-term use — are being written for this age group.

Mark Olfson, MD, MPH, at the New York State Psychiatric Institute and Columbia University; Marissa King, PhD, at Yale University; and Michael Schoenbaum, PhD, at NIMH used data from the IMS LifeLink LRx Longitudinal Prescription database and a national database on medical expenditures collected by the Agency for Healthcare Research and Quality to examine prescription patterns from 2008.

The researchers found that among adults aged 18 to 80 years, about one in 20 received a benzodiazepine prescription in 2008, the period covered by the study. But this fraction rose substantially with age, from 2.6% among those aged 18 to 35 years, to 8.7% in those aged 65 to 80 years. Long-term use — a supply of the medication for more than 120 days — also increased with age. Of people aged 65 to 80 years who used benzodiazepines, 31.4% received prescriptions for long-term use, vs. 14.7% of users aged 18 to 35 years. In all age groups, women were about twice as likely as men to receive benzodiazepines. Among women aged 65 to 80 years, 1 in 10 was prescribed one of these medications, with almost a third of those receiving long-term prescriptions.

“These new data reveal worrisome patterns in the prescribing of benzodiazepines for older adults, and women in particular,” said Thomas Insel, MD, director of the National Institute of Mental Health (NIMH), which supported the study. “This analysis suggests that prescriptions for benzodiazepines in older Americans exceed what research suggests is appropriate and safe.”

In older people, research has shown that benzodiazepines, prescribed to treat anxiety and sleep problems, can impair cognition, mobility, and driving skills, and they increase the risk of falls. Commonly prescribed benzodiazepines include alprazolam (Xanax), diazepam (Valium), and lorazepam (Ativan). The study found that most prescriptions for benzodiazepines are written by non-psychiatrists. For adults 18 to 80 years old, about two thirds of prescriptions for long-term use are written by non-psychiatrists; for adults aged 65 to 80 years, the figure is 9 out of 10.

The study appears online in JAMA Psychiatry (JAMA Psychiatry 2014 Dec 17. doi: 10.1001/jamapsychiatry.2014.1763. [Epub ahead of print]).

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severity of the risks (think of the television ads listing possible drug side effects starting with death). Your efforts to minimize those risks, such as therapeutic trials or gradual introduction of the requested regimen should be detailed. A change in food consistency or the resident’s position might be initiated at lunchtime, when resident function and facility staffing is likely to be greatest. Close observation, close accessibility of suction equipment, and other possible safety measures should be explored and documented as should the results of the first few trials. The decision should be revisited as two or three episodes of severe choking might lead to a different decision.

Our goal must remain to encourage our residents to their highest attainable level of functioning, to the greatest possible control over their own lives. Mealtime is one of the few occasions when residents can assert control. These choices should be honored.

Dr. Nichols is president of the New York Medical Directors Association and a member of the Caring for the Ages Editorial Advisory Board. Comment on this and other columns at www.caringfortheages.com under “Views.”