Decision-Making Regarding Nasogastric Tube Feeding at the End of Life: A Scoping Review

Tomada de Decisão Sobre Alimentação Entérica por Sonda Nasogástrica em Fim de Vida: Uma Revisão do Escopo
Toma de Decisiones Sobre la Alimentación Entérica Mediante Sonda Nasogástrica al Final de la Vida: Una Revisión del Alcance

RESUMO
Objetivo: Mapear a evidência científica sobre as dificuldades dos profissionais de saúde na tomada de decisão sobre a alimentação entérica por sonda nasogástrica em doentes em fim de vida. **Método:** Scoping review conduzida segundo a metodologia do Joanna Briggs Institute e PRISMA-ScR. Incluíram-se estudos primários sobre dificuldades na tomada de decisão em fim de vida, publicados entre 2020–2025, em inglês, espanhol e português. A pesquisa foi realizada nas bases PubMed, Web of Science e CINAHL, com descritores e operadores booleanos. **Resultados:** Foram incluídos seis estudos, identificando-se seis categorias de dificuldades: formação e conhecimento; dimensão ética; dimensão clínica; crenças; fatores familiares e contexto do cuidar. **Conclusão:** A tomada de decisão dos profissionais de saúde sobre a alimentação entérica por sonda nasogástrica em doentes em fim de vida é influenciada por fatores interligados, destacando-se a formação insuficiente e a ausência de diretrizes clínicas, reforçando a necessidade de formação contínua, protocolos baseados na evidência e comunicação eficaz.
DESCRITORES: Cuidados Paliativos; Fim de Vida; Nutrição Enteral; Tomada de Decisão; Enfermagem.

ABSTRACT
Objective: To map the scientific evidence regarding the difficulties healthcare professionals face in making decisions about nasogastric tube feeding in end-of-life patients. **Method:** Scoping review conducted according to the Joanna Briggs Institute and PRISMA-ScR methodologies. Primary studies on decision-making difficulties at the end of life, published between 2020 and 2025 in English, Spanish, and Portuguese, were included. The search was conducted in the PubMed, Web of Science, and CINAHL databases, using descriptors and Boolean operators. **Results:** Six studies were included, identifying six categories of difficulties: training and knowledge; ethical dimension; clinical dimension; beliefs; family factors; and care context. **Conclusion:** Decision-making by healthcare professionals regarding enteral feeding via nasogastric tube in end-of-life patients is influenced by interrelated factors, notably insufficient training and the absence of clinical guidelines, reinforcing the need for continuing education, evidence-based protocols, and effective communication.
DESCRIPTORS: Palliative Care; End of Life; Enteral Nutrition; Decision Making; Nursing.

RESUMEN
Objetivo: Recopilar la evidencia científica sobre las dificultades de los profesionales sanitarios a la hora de tomar decisiones sobre la alimentación entérica mediante sonda nasogástrica en pacientes en fase terminal. **Método:** Revisión exploratoria realizada según la metodología del Joanna Briggs Institute y PRISMA-ScR. Se incluyeron estudios primarios sobre las dificultades en la toma de decisiones al final de la vida, publicados entre 2020 y 2025, en inglés, español y portugués. La búsqueda se realizó en las bases de datos PubMed, Web of Science y CINAHL, utilizando descriptores y operadores booleanos. **Resultados:** Se incluyeron seis estudios, en los que se identificaron seis categorías de dificultades: formación y conocimientos; dimensión ética; dimensión clínica; creencias; factores familiares y contexto asistencial. **Conclusión:** La toma de decisiones de los es de la salud sobre la alimentación entérica por sonda nasogástrica en pacientes al final de la vida se ve influida por factores interrelacionados, entre los que destacan la formación insuficiente y la ausencia de directrices clínicas, lo que refuerza la necesidad de formación continua, protocolos basados en la evidencia y una comunicación eficaz.
DESCRIPTORES: Cuidados paliativos; Fin de la vida; Nutrición enteral; Toma de decisiones; Enfermería.

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INTRODUCTION

Eating is a fundamental aspect of life, carrying deep emotional, cultural, and symbolic significance for both the patient and the family, and is a cross-cutting issue in end-of-life care [1–3]. The progression of an incurable or severe disease in an advanced,

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progressive, and terminal stage is often associated with a deterioration in the patient's general condition, manifested by dysphagia, anorexia, xerostomia, nausea, and vomiting [1,3-5] . In addition to the impact on the patient's comfort, these symptoms cause distress for family members and caregivers, who tend to associate the act of feeding with care, affection, and the preservation of life [3,5-6] . In this context, the use of artificial feeding methods, such as the nasogastric tube (NGT), raises complex ethical, clinical, and emotional issues [5,7-8] . The administration of artificial nutrition and hydration (ANH) in the terminal phase remains controversial, with no consensus regarding its classification as basic care or medical treatment, which contributes to disagreements among stakeholders in the decision-making process [1-2,6] . Historically, ANH has been promoted as a beneficial intervention, associated with maintaining nutritional status, preventing infections, preserving skin integrity, and improving functional prognosis, with the underlying belief that it may prolong survival [3] .Beyond their clinical utility, these interventions are often interpreted as expressions of care and compassion[3,5-6] , and their suspension is frequently—and mistakenly—perceived as abandonment or neglect [2,5,7] . This perception is exacerbated by family pressure, fear that the patient is "starving" or "suffering from thirst," and by the insecurity felt by healthcare professionals themselves [3,5] . The complexity of this decision is reflected in healthcare professionals (HCPs), who do not always have up-to-date training or clear clinical guidelines, contributing to clinical uncertainty and emotional vulnerability at the time of decision-making [1,5] . Thus, it is pertinent to conduct a *scoping review* (ScR) with the objective of mapping the scientific evidence regarding the difficulties experienced by HPs in clinical decision-making regarding enteral feeding via NG tube in end-of-life patients.

In this study, clinical decision-making refers to the process by which HCPs integrate scientific evidence, professional experience, and the patient's context to determine the most appropriate decision. Difficulties correspond to barriers perceived by HCPs that may limit or complicate this decision-making process.

METHOD

This scoping review was conducted in accordance with the methodological guidelines of the Joanna Briggs Institute (JBI) and the guidelines of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) [9-10] for the description of review protocols. The defined research question was: *What are the difficulties faced by healthcare professionals in decision-making regarding enteral feeding via NG tube in end-of-life patients?* Study selection was based on the PCC strategy, including: (p) healthcare professionals defined as physicians, nurses, dietitians, and other professionals involved in clinical decision-making, as well as students in clinical training settings; (c) difficulties in decision-making regarding enteral feeding via NG tube; and (cxt) adult patients at the end of life and/or in palliative care (PC), in different care settings. We considered primary studies of a qualitative, quantitative, or mixed-methods nature, published between 2020 and 2025, available in full text, open access, in English, Spanish, and Portuguese. We excluded review articles, editorials, letters to the editor, and studies that did not directly address decision-making regarding enteral feeding at the end of life. The search was conducted on March 12, 2025, in the PubMed, Web of Science, and CINAHL Complete (via EBSCO) databases, following the three-step strategy recommended by the JBI [9] . The choice of electronic databases is due to their broad coverage of international scientific literature and the assurance of access to indexed and peer-reviewed studies. Following an initial exploratory search to identify MeSH and DeCS descriptors, the following Boolean equation was constructed: (Palliative care OR Terminal care OR End of life care) AND (Clinical decision-making OR Ethical issues) AND (Enteral nutrition OR Tube feeding). The references of the included studies were also analyzed. The results were managed in EndNote Web, with duplicates removed. Screening was conducted in two phases (title/abstract and full text) , performed by two independent reviewers, with disagreements resolved by consensus or a third reviewer. Reasons for exclusion were recorded. To minimize the risk of error in data extraction, a data extraction tool previously defined and tested by the reviewers was used, ensuring consistency and rigor in the collection of relevant information.

RESULTS

The search across the three databases identified 993 studies, of which 626 were in PubMed, 27 in CINAHL, and 340 in Web of Science. After removing 116 duplicates, 877 articles were evaluated based on title and abstract. Application of the inclusion criteria allowed for the selection of 30 studies for full-text review. Analysis of the references from these articles resulted in the inclusion of 2 additional studies, bringing the total to 32 articles evaluated in full. A data extraction tool developed by the authors was used, including: author, year, country, study design, participants, objectives, and main results. With the aid of the data extraction tool and after applying the eligibility criteria, 26 studies were excluded. Thus, the final sample consisted of 6 studies that met all inclusion criteria. The complete study selection process is presented in the PRISMA flowchart in Figure 1.

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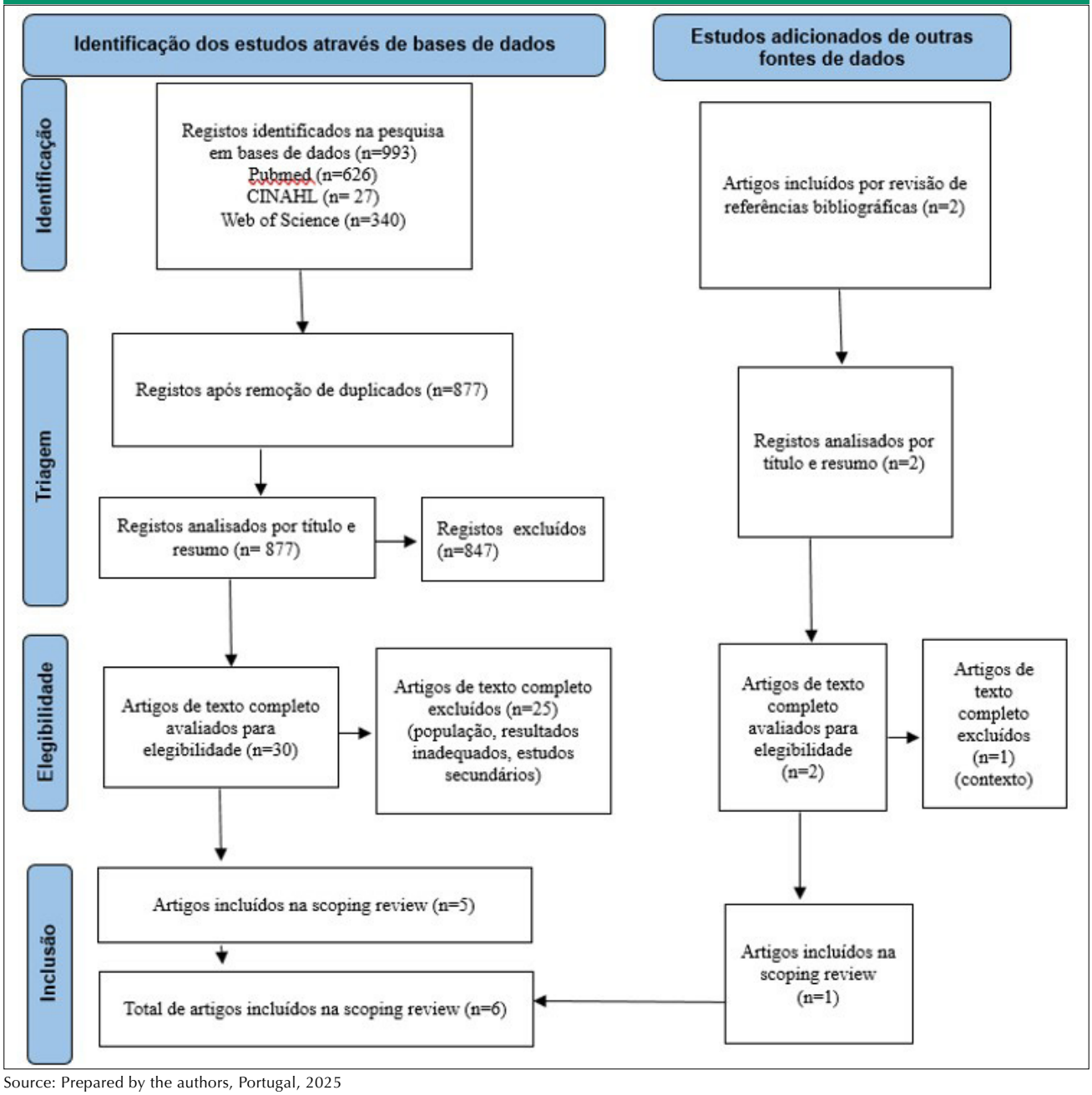
Figure 1 - Study selection process based on the PRISMA flowchart



Source: Prepared by the authors, Portugal, 2025

The six included studies were published between 2020 and 2024: one in 2020, two in 2021, one in 2022, and two in 2024. Regarding the methodological design, three studies are qualitative and three are quantitative. In terms of geographic distribution, the studies were conducted in Italy, Spain, South Africa, Israel, Turkey, and the Netherlands, demonstrating geographic heterogeneity. The settings included hospital units, Residential Care Facilities for the Elderly (RCFEs), and specialized palliative care centers. Regarding the study population, three studies involved nurses and nursing students, two included healthcare professionals from different categories (nurses, physicians, nutritionists, and social workers), and one included speech therapists. Table 1 presents the main characteristics of the included studies.

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Table 1 - Characterization of Studies Included in the ScR

No.	Study Title	Author	Year	Country	Study Design	Participants
1	A bridge to cross: Tube feeding and the barriers to implementation of palliative care for the advanced dementia patient	Matarasso-Greenfeld et al.	2022	Israel	Qualitative study with semi-structured interviews	27 palliative care units in 7 long-term care facilities (13 nurses; 6 physicians; 5 dietitians; 3 social workers)
2	Between choice, necessity, and comfort: Deciding on tube feeding in the acute phase after a severe stroke	Frey et al.	2020	Netherlands	Qualitative ethnographic study (participant observation and interviews)	16 Patients, emergency department staff, and family members in stroke units
3	Enhancing nutritional care in palliative care units: assessing nurse knowledge and quality perception in enteral nutrition practices	Batu et al.	2024	Turkey	Cross-sectional, quantitative descriptive study	205 Nurses from 25 palliative care units
4	Tube feeding in advanced dementia: Insights from South African speech-language therapists	Pullen et al.	2024	South Africa	Qualitative study with semi-structured interviews	8 speech-language therapists with experience/training in patients with dementia
5	Nurse and Nursing Students' Opinions and Perceptions of Enteral Nutrition via Nasogastric Tube in Palliative Care	Sánchez-Sánchez et al.	2021	Spain	Cross-sectional quantitative study	511 participants (383 nurses and 128 nursing students)
6	Oncology and palliative care nurses' knowledge and attitudes toward artificial nutrition and hydration for patients at end of life in Italy	Albanesi et al.	2021	Italy	Cross-sectional quantitative study	454 nurses (oncology and palliative care)
5	Nurse and Nursing Students' Opinions and Perceptions of Enteral Nutrition by Nasogastric Tube in Palliative Care	Sánchez-Sánchez et al.	2021	Espanha	Estudo quantitativo transversal	511 participantes (383 enfermeiros e 128 estudantes de enfermagem)
6	Oncology and palliative care nurses' knowledge and attitudes toward artificial nutrition and hydration for patients at end of life in Italy	Albanesi et al.	2021	Itália	Estudo quantitativo transversal	454 enfermeiros (oncologia e cuidados paliativos)

Source: Prepared by the authors, Portugal, 2025

The objectives and main results of the included studies were summarized in accordance with the objective of the ScR (Table 1).

Chart 1 - Summary of the objectives and results of the included studies

No.	Objective	Results
1	To understand primary care providers' knowledge of CP and their motivations for implementing SNG in advanced dementia	Vague knowledge of CP and imprecise use of terminology. Revealed a lack of education and training on comfort feeding. Gaps in knowledge regarding guidelines; personal beliefs are confused with scientific knowledge; believe that SNG prolongs life, without an evidence base. Family members: fear that the patient will "starve to death" without SNG, influencing healthcare providers' decisions.
2	To understand the decision-making process regarding TPN in 16 patients after severe stroke.	Three frameworks identified: choice (autonomy and patient autonomy), necessity (medical indication and diagnosis), and comfort (reduction of patient suffering). The frameworks may coexist, complement each other, or conflict; they reflect tensions between medical ethics, prognosis, and family preferences. "Need" reflects medical paternalism; "choice" prioritizes patient autonomy; "comfort" attempts to integrate palliative care to avoid unnecessary end-of-life interventions.
3	To determine the levels of knowledge among nurses working in palliative care units regarding enteral nutrition practices	Nurses' knowledge levels regarding enteral nutrition practices were significantly influenced by training in enteral nutrition and the frequency of SNG use in their units. Training in palliative care, duration of experience in palliative care, and years of professional experience had no statistically significant effect on knowledge scores.
4	Describe speech-language pathologists' practices regarding tube feeding in advanced dementia	They report a lack of awareness of existing guidelines or believe their scope is limited; personal/cultural and religious beliefs; family pressure; lack of DAV; caregiver burnout; acute care settings favor the use of SNG; instrumental assessment is prioritized; perception of SNG as temporary; inadequate staff-to-patient ratios influence decisions; they consider a multidisciplinary approach important.
5	To describe the opinions and perceptions of nurses and nursing students regarding enteral nutrition using NG tubes in adult patients in critical care, analyzing the influence of academic training and professional experience	Among participants (nurses/students), 57.7% believe the decision should be shared; 31.1% consider it the responsibility of family members/caregivers; few attribute it exclusively to nurses (5.3%) or to the patient (2.1%). Nutrition (34.3%), life expectancy (21.5%), symptom control (21.3%), and patient autonomy (19.5%) were the most frequently cited criteria for initiating TPN. Support for TPN decreases as death approaches: 90% (>6 months), 81.6% (1–6 months), 42.5% (<1 month). More nurses than students support TNS in patients with <1 month to live; Nurses showed a greater propensity to discontinue TNS in the final days of life than students. 96.1% advocate respecting autonomy in the decision to maintain or discontinue enteral nutrition. Professional experience affects perceptions regarding initiating or discontinuing TNS
6	To describe the knowledge and attitudes of oncology and palliative care nurses regarding home enteral nutrition at the end of life.	The authors identified knowledge gaps and ambiguous attitudes among nurses, affecting clinical practice and decision-making. Uncertainty regarding the use of EN and emotional and cultural factors influence decisions. Knowledge gaps and ambiguous attitudes affect practice; misconceptions about the effects of EN on symptoms persist, despite reasonable knowledge of its principles. Nurses widely recognize risks (pain, infection, burden), but there is less agreement on emotional benefits, especially among palliative care professionals. Professional experience and the clinical context influenced attitudes and the level of agreement regarding the continuation or discontinuation of ANH at the end of life.

Source: Prepared by the authors, Portugal, 2025

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To systematize the results, the difficulties identified in decision-making regarding TPN in end-of-life patients were grouped into thematic categories (Table 2).

Chart 2 - Difficulties Faced by Healthcare Professionals in Decision-Making

Thematic Category	Difficulty	Studies Cited	Number of articles in which it was referenced	FR (%)
Training and Knowledge	Insufficient Training	N1; N3; N4; N5; N6	5	83.3
	Lack of Guidelines/Protocols	N1; N4; N6	3	50
Ethical Dimension	Patient Autonomy	N2; N5; N6	3	50
	Ethical Dilemma	N2; N4;	2	33.3
	Patient Comfort	N2; N6	2	33.3
	Lack of Advance Directives	N2; N4	2	33.3
Clinical Dimension	Dependent on Medical Diagnosis	N2; N4	2	33.3
	Uncertainty regarding duration of SNG use	N4	1	16.6
	Life Expectancy	N2; N5	2	33.3
Beliefs	Personal, cultural, and religious beliefs of patients and family members	N1; N4; N6	3	50
Family Factors	Pressure exerted by family members	N1; N2; N4	3	50
	Caregiver Burden	N4	1	16.6
Caregiving Context	Nature of the clinical setting	N2; N4	2	33.3
	Inadequate PS ratios	N4	1	16.6
	Need for a multidisciplinary approach	N4	1	16.6

Source: Prepared by the authors, Portugal, 2025

After analyzing the results regarding the difficulties healthcare professionals face in making decisions about TPN feeding for end-of-life patients, six categories emerged: Training and knowledge; Ethical dimension; Clinical dimension; Beliefs; Family factors; and Care context. It was found that the most frequently identified category was Training and knowledge, mentioned in five of the six studies, with insufficient training and the absence of clear guidelines being highlighted. Beliefs and Family factors were mentioned in three studies each, highlighting the influence of personal, cultural, and family factors on the decision-making process. The remaining categories, such as Ethical Dimension, Clinical Dimension, and Care Context, were identified in fewer studies, ranging from one to three, including aspects such as patient autonomy, clinical criteria, family pressure, and institutional constraints.

DISCUSSION

This ScR identified a broad range of difficulties faced by HCPs in making decisions regarding TPN for end-of-life patients. The results demonstrate that this decision is complex and multidimensional, influenced by educational, clinical, ethical, cultural, emotional, and organizational factors [10–14,15] . These findings corroborate the literature, which describes end-of-life artificial nutrition as an area marked by uncertainty, controversy, and variability in practices [1,7-8] .

Insufficient training of healthcare professionals [11-15] emerges as the main difficulty in deciding whether to place a nasogastric tube (NGT) in end-of-life patients. This gap compromises the ability to critically assess the potential benefits and risks of TPN- , favoring decisions based primarily on individual experience or institutionalized practices, which are not always aligned with available scientific evidence [11,13] . The absence of clear clinical guidelines and the persistent controversy surrounding NHA further contribute to uncertainty and inconsistency in decision-making [11-15] . Although scientific evidence questions the benefits of SNG in end-of-life contexts and highlights its potential risks [5,16], its use remains frequent, suggesting a dis-

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connect between scientific knowledge and clinical practice. These findings reinforce the need to invest in specific training and the development of clinical guidelines that support more consistent, evidence-based decisions [1,4,7,18].

~~The~~ **ethical dimension** is a central pillar of decision-making, reflecting the challenges faced by healthcare professionals regarding respect for *patient autonomy* [11,15–16], the promotion of *patient comfort, and the management of uncertainty and ambiguity* [11,16], *as well as the presence or absence of DAV* [14,16]. HCPs face ethical dilemmas that require careful consideration of the four principles of bioethics: autonomy, beneficence, non-maleficence, and justice. The "repertoire" model by Frey et al. [16] illustrates this complexity by highlighting the coexistence of different decision-making logics—choice (valuing autonomy), necessity (paternalistic approach), and comfort (focus on alleviating suffering)—which may complement or conflict with one another. The literature reinforces these difficulties, indicating that the absence of clear and up-to-date ADRs accentuates ambiguity, often leading to decisions based on subjective interpretations or presumed wishes. Even when ADRs exist, they may be viewed as vague or outdated, reinforcing the need for advance care planning and ongoing communication between the patient, family members, and the healthcare team [4,19]. The ScR findings are consistent with evidence that questions the actual benefit of TPN at the end of life, prioritizing decision-making centered on the patient's comfort and wishes [5,8,17,20].

The patient's clinical condition, particularly their life expectancy, is one of the most frequently considered aspects in the decision regarding the use of TPN [15-16] and reliance on medical criteria and instrumental assessments, as it provides healthcare professionals with greater confidence in their decision [14,16]. In the study by Sánchez-Sánchez et al. [15], 90% of participants supported TPN-based NHA when life expectancy was greater than six months, while 57.5% discouraged it when life expectancy was less than one month, particularly among experienced nurses. Chauhan et al. [8] reinforce these findings, noting that most indications for SNG feeding are related to dysphagia; however, despite the biomedical rationale underpinning these decisions, functional prognosis and disease progression are not always considered [7,20]. In one study, the lack of clarity regarding the duration of SNG use was cited as a challenge, as it is often perceived as a temporary intervention, especially in acute hospital settings; however, this perception is not usually accompanied by clear plans for reassessment or well-defined therapeutic goals, which can lead to prolonged maintenance of TNS even when there are no longer any clinical benefits [14]. The literature demonstrates that the absence of institutional protocols for discontinuing or reviewing TNS contributes to its overuse [18].

In half of the studies included in this ScR [11,13-14], the personal, cultural, and religious beliefs of healthcare providers and families were identified as factors that significantly influence clinical decision-making. In some cases, healthcare providers base their interventions on personal convictions, often associated with a lack of clinical knowledge. In the study by Matarasso-Greenfeld et al. [13], for example, some participants believed that the use of TPN could prolong life, despite acknowledging that this perception is not supported by scientific evidence. At the same time, families tend to associate feeding with survival and express fear that the patient will "starve to death," which may drive the use of TPN even in the absence of clinical indication [13-14]. The literature highlights that the strong symbolic and emotional weight associated with feeding at the end of life, combined with limited health literacy regarding the dying process, may contribute to decisions guided more by cultural and emotional values than by clinical criteria [2-3,5-6,17]. In this context, the cultural belief that "feeding is caring" remains deeply rooted, creating pressure to maintain TPN even in patients with an irreversible prognosis [8,20].

The pressure exerted by family members, reported in half of the included studies [13-14,16], poses a challenge for healthcare professionals, especially when combined with caregiver burnout [14]. In the study by Sánchez-Sánchez et al. [15], 57.7% of nurses and nursing students argued that the decision regarding the use of TPN should be shared among the patient, family, and healthcare team. However, a significant proportion (31.1%) attributes this responsibility exclusively to the family or caregivers, while only a minority (2.1%) attributes it directly to the patient. These data highlight the central role often attributed to the family in decision-making, but also the lack of clarity regarding the distribution of responsibilities, which can lead to feelings of guilt, exclusion, and conflicts with the healthcare team [4]. The literature describes feeding as an act of care and hope [3,5-6], so its suspension may be interpreted by families as abandonment [2,3]. In these contexts, tube feeding can represent a concrete form of action for family members, symbolizing continuity of care and preventing feelings of guilt and abandonment [7].

Finally, the care setting influences decision-making. The clinical environment, including the type of unit and the availability of resources, directly affects the practice of tube feeding and the decision-making of healthcare professionals [14,16]. In certain contexts, such as stroke units or hospital wards, there is a greater

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tendency to initiate tube feeding as a temporary intervention, regardless of the prognosis [16] . The overload on healthcare professionals, associated with inadequate staffing ratios, favors practices driven by operational efficiency at the expense of individualized care [14] . The Japanese reality presented by Aoki et al. [21] illustrates this institutional pattern: TNS is widely used in terminally ill patients, in contrast to countries where comfort is prioritized. This finding shows that the prevalence of SNG is higher in institutions where the biomedical model of care predominates and where the philosophy of palliative care is not integrated, highlighting the importance of promoting organizational cultures centered on comfort, autonomy, and dignity at the end of life. One study highlighted the absence of interdisciplinary approaches, compromising shared decision-making and coordination between different clinical and ethical perspectives [14] . Thus, instead of a collective reflection on the proportionality and objectives of care, decisions end up being made in a fragmented manner, often centered on medical authority or family pressure, without the full involvement of the team [14] . In addition to the organizational factors already mentioned, the literature also indicates that the decision to maintain or suspend NHA via SNG may be influenced by **issues** such as the **cost of the intervention**, **staff availability**, **fear of litigation,** or even **fear of** negative **public repercussions** [7] . These data demonstrate that, in many contexts, the decision is not exclusively clinical, but also contextual and organizational.

The results of this ScR highlight the need to promote a more structured and integrated approach to end-of-life decision-making, grounded in the training of healthcare professionals, scientific evidence, the development of clear clinical guidelines, and effective communication. The integration of the philosophy of palliative care and interdisciplinary approaches may contribute to more consistent decisions, centered on the patient's values and oriented toward therapeutic proportionality at the end of life. For nursing practice, these results highlight the importance of developing competencies in end-of-life communication, shared decision-making, and the assessment of the proportionality of nutritional interventions in a palliative care context. In this regard, nurses play a key role in identifying the needs of the patient and family, as well as in mediating the decision-making process among the patient, family, and healthcare team, contributing to informed, ethically grounded decisions centered on the patient's values and comfort.

Despite the consistency of the results, this ScR has some limitations, namely the small number of studies, the inclusion only of studies published in Portuguese, English, and Spanish, and the exclusion of articles without access to the full text, which may have limited the scope of the mapping. Additionally, cultural, organizational, and legislative differences among the countries analyzed may limit the generalizability of the results. Nevertheless, the findings of this systematic review are consistent with the existing literature, which describes similar difficulties in decision-making regarding end-of-life artificial nutrition, particularly with regard to insufficient training of primary care physicians [1,4,7,18] , the influence of family factors [2-3,(7)] ,and the ethical tensions associated with the decision-making process [5,8,17,20] . These results reinforce the need for further research and the development of strategies to support primary care physicians in end-of-life decision-making.

CONCLUSION

This ScR identified the main challenges faced by healthcare professionals when making decisions regarding nasogastric tube feeding for end-of-life patients. The results indicate that this decision is influenced by multiple interrelated factors, such as clinical, ethical, personal, cultural, and institutional factors, which often generate tensions and ambivalence. The main challenges highlighted include insufficient training of healthcare professionals and the absence of specific clinical guidelines. Added to these are ethical challenges, such as respect for patient autonomy and the absence of advance directives; clinical challenges, such as uncertainty regarding life expectancy and the need for medical criteria and instrumental assessments; and sociocultural challenges, namely the influence of healthcare professionals' personal and cultural beliefs and pressure from family members. The care context, characterized by acute clinical settings, a shortage of human resources, and the absence of interdisciplinary teams, also contributes to the prioritization of TPN over comfort feeding. Improving clinical practice requires investment in continuing education, the development of evidence-based clinical protocols, the promotion of effective communication with patients and families, and the strengthening of interdisciplinary approaches centered on dignity and comfort at the end of life. Educational and healthcare institutions must integrate these dimensions into training programs and clinical practice, ensuring more informed, ethical, and patient-centered decisions. Contributing to more informed and proportionate end-of-life decisions is an ethical and clinical imperative, essential to the quality of care provided.

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