Ethics and clinically assisted nutrition or hydration approaching the end of life – Decision Tree

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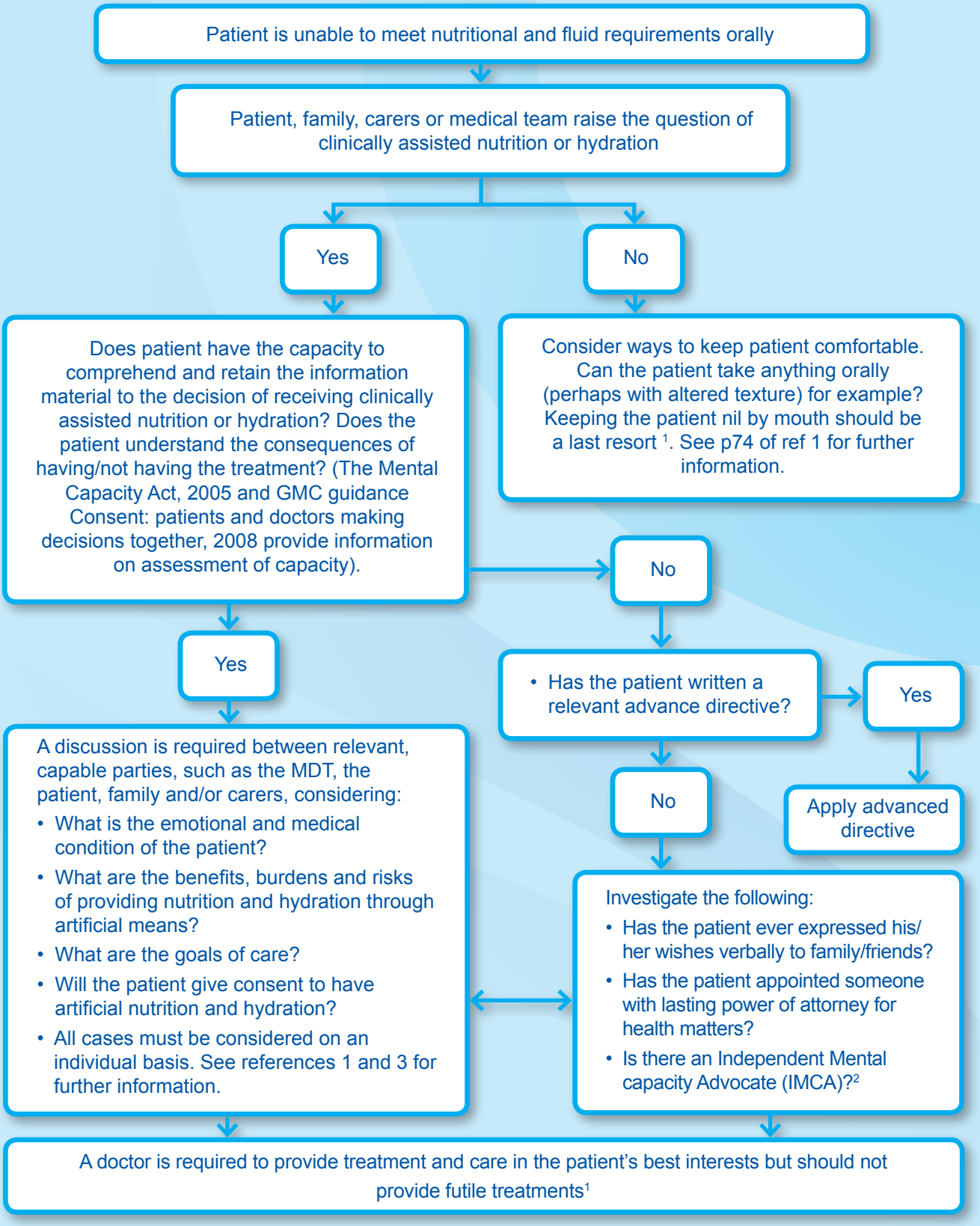

Ethics and clinically assisted nutrition or hydration approaching the end of life –

Key Points

- **Nutrition and hydration provided by tube or drip are regarded in law as medical treatment, and should be treated in the same way as other medical interventions.[3]**
- **There is no ethical or legal distinction between withholding and withdrawing treatment. However, compared with the withholding of nutrition support, the withdrawal of treatment may cause more emotional distress for HCPs, patients and carers.[4]**
- **Patients can not insist on an inappropriate treatment, but can refuse treatments.[1]**
- **Relatives can assent but not consent on behalf of a patient lacking mental capacity. It is the doctors duty to make a decision based on full discussion with all interested parties.[1]**
- **Healthcare professionals that may be involved in the care of patients approaching the end of life include doctors, speech and language therapists, dietitians, specialist nurses (such as Nutrition Nurses; MacMillian Nurses) and the palliative care team.**

Patients with Capacity:[3]

Offer the patient treatments you consider to be clinically appropriate because, for example they would provide symptom relief. Explain to the patient the benefits, burdens and risks associated with the treatments, so that the patient can make a decision about whether to accept them.

If you assess that clinically assisted nutrition or hydration would not be clinically appropriate, you must monitor the patient's condition and reassess the benefits, burdens and risks of providing clinically assisted nutrition or hydration as the patient's condition changes. If a patient asks you to provide nutrition or hydration by tube or drip, you should discuss the issues with the patient and explore the reasons for their request. You must reassess the benefits, burdens and risks of providing the treatment requested.

When the benefits, burdens and risks are finely balanced, the patient's request will usually be the deciding factor. However, if after discussion you still consider that the treatment would not be clinically appropriate, you do not have to provide it. But you should explain your reasons to the patient and explain any other options that are available, including the option to seek a second opinion.

Adult patients who lack capacity & are not expected to die within hours/days:[3]

If a patient is in the end stage of disease, but death is not expected within hours/days, you must provide clinically assisted nutrition or hydration if it would be of overall benefit, taking into account the patient's beliefs and values, any previous request for nutrition or hydration by tube or drip. The patient's request must be given weight and, when the benefits, burdens and risks are finely balanced, will usually be the deciding factor.

If you judge that providing clinically assisted nutrition or hydration would not be of overall benefit to the patient, you may conclude that the treatment should not be started at that time or should be withdrawn. You should explain your view to the patient, if appropriate, and those close to them. In these circumstances you must make sure that the patient's interests have been thoroughly considered. This means you must take all reasonable steps to get a second opinion from a senior clinician who has experience of the patient's condition but who is not directly involved in the patient's care. If this is not possible for practical reasons, you must still get advice from a colleague. You should also consider seeking legal advice.

If you reach a consensus that clinically assisted nutrition or hydration would not be of overall benefit to the patient and the treatment is withdrawn or not started, you must make sure that the patient is kept comfortable. You must monitor the patient's condition and be prepared to reassess the benefits, burdens and risks of providing clinically assisted nutrition or hydration in light of changes in their condition.

If clinically assisted nutrition or hydration is started or reinstated after a later assessment, and you subsequently conclude that it would not be of overall benefit to continue with the treatment, you must seek a second opinion (or, if this is not possible, seek advice) as above.

Adult patients who lack capacity and are expected to die within hours or days:[3]

If a patient is expected to die within hours or days, and you consider that the burdens or risks of providing clinically assisted nutrition or hydration outweigh the benefits they are likely to bring, it will not usually be appropriate to start or continue treatment. You must consider the patient's needs for nutrition and hydration separately.

If a patient has previously requested that nutrition or hydration be provided until their death, or those close to the patient are sure that this is what the patient wanted, the patient's wishes must be given weight and, when the benefits, burdens and risks are finely balanced, will usually be the deciding factor.

You must keep the patient's condition under review, especially if they live longer than you expected. If this is the case, you must reassess the benefits, burdens and risks of providing clinically assisted nutrition or hydration, as the patient's condition changes.

Please note that if you are considering withdrawing nutrition or hydration from a patient in PVS or a condition closely resembling PVS, the courts in England, Wales and Northern Ireland currently require that you approach them for a ruling.

The courts in Scotland have not specified such a requirement, but you should seek legal advice on whether a court ruling may be necessary in an individual case.[3]

References

1. Royal College of Physicians and British Society of Gastroenterology: Oral feeding difficulties and dilemmas towards the end of life: London, Royal College of Physicians, 2010
2. Mental capacity Act 2005: UK, The Stationary Office Limited, 2005
3. General Medical Council: Treatment and care towards the end of life: good practice in decision making: London, 2010
4. Geppert CMA, Andrews MR, Duryan ME. JPEN. 2010; 34:79-88

Further Reading

- MCPCIL: Liverpool Care Pathway for the Dying Patient [homepage on the internet]. Available at: http://www.liv.ac.uk/mcpcil/liverpool-care-pathway/
- General Medical Council: Consent: patients and doctors making decisions together: London, 2008