Nutrition In Palliative Care

NUTRITION IN PALLIATIVE CARE: ETHICAL APPROACH

C. Druml (AT)
Nutrition in palliative care

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Declaration

I declare,
that I have no conflict of interest

Christiane Druml
Yesterday versus today?
Palliative Care: the beginning
”Low tech and high touch”

Cicely Saunders, 2018 – 2005, English Doctor, nurse, social worker, physician and writer, an Anglican, and involved with terminal care research and engaged with international universities.

Married to Polish painter Marian Bohusz-Szyszko.
Palliative care I

WHO Definition

Improves the quality of life of patients and their families,

• facing the problem associated with life-threatening illness,
• through the prevention and relief of suffering by means of early identification and impeccable assessment and
• treatment of pain and other physical, psychosocial and spiritual problems.
Palliative care II

• Is a life-affirming approach that views dying as a normal process that,
• while it should not be accelerated,
• ought not to be impeded or prolonged either.

The aim is to foster and sustain an optimal quality of life until death.
A change of paradigm?

Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer


Abstract

BACKGROUND
Patients with metastatic non–small-cell lung cancer have a substantial symptom burden and may receive aggressive care at the end of life. We examined the effect of introducing palliative care early after diagnosis on patient-reported outcomes and end-of-life care among ambulatory patients with newly diagnosed disease.

METHODS
We randomly assigned patients with newly diagnosed metastatic non–small-cell lung cancer to receive either early palliative care integrated with standard oncologic care or standard oncologic care alone.

August 19, 2010
N Engl J Med 2010; 363:733-742
DOI: 10.1056/NEJMoa100678

Related Articles

EDITORIAL AUG 19, 2010
Palliative Care — A Shifting Paradigm
A.S. Kelley and D.E. Meier

CORRESPONDENCE DEC 2, 2010
Early Palliative Care in Non–Small-Cell Lung Cancer

NEJM CareerCenter
Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer


Twelve-Week Outcomes of Assessments of Mood.
e-SPEN guideline

ESPEN guideline on ethical aspects of artificial nutrition and hydration

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Structure of the guideline I

- 36 Recommendations („Statements“),
- Each one with a Comment to the following aspects:
  - Methodology
  - Ethical Framework
  - Fundamentals
Structure of the guideline II

Special Situations
- Old age
- Dementia
- PVS
- Palliative care
- The dying patient
- Nursing care
- Intensive care

Will, information and Consent
- Patient’s rights
- Capacity to consent
- Advance directives
- Presumed consent
- Quality of life
Structure III

Difficult decisions and ethical dilemmas

- Disagreement & tensions between decision makers
- Withholding & withdrawing nutrition and hydration support therapy
- Voluntary refusal of nutrition and fluids

Culture and religion
- Religious specifics
- Christianity: catholic church
- Christianity: protestant church
- Jewish halacha
- Islam

- Forced feeding
Basics from the medical point of view
Ethics in artificial nutrition

Artificial nutrition

Enteral nutrition

Parenteral nutrition

But:
Not the nutrition is artificial,
It is the way of administration
Ethics in artificial nutrition

Artificial nutrition

≡

Medical intervention

therefore

It is not a „fundamental right“ of a human being

compared with directly or indirectly wished for and orally offered nutrition or hydration
INDICATION
Therapeutic goal achievable?

yes

Will of the patient or decision of surrogate

treatment: yes

treatment: no

TREATMENT

no

NO TREATMENT
Artificial nutrition and hydration are given to a patient following a medical indication and imply choices concerning medical procedures and devices (perfusion, feeding tubes).

Artificial nutrition and hydration are regarded in a number of countries as forms of treatment, which may therefore be limited or withdrawn in the circumstances and in accordance with the guarantees stipulated for limitation or withdrawal of treatment (refusal of treatment expressed by the patient, refusal of unreasonable obstinacy or disproportionate treatment assessed by the care team and accepted in the framework of a collective procedure). The considerations to be taken into account in this regard are the wishes of the patient and the appropriate nature of the treatment in the situation in question.

In other countries, however, it is considered that artificial nutrition and hydration do not constitute treatment which can be limited or withdrawn, but a form of care meeting the individual’s basic needs, which cannot be withdrawn unless the patient, in the terminal phase of an end-of-life situation, has expressed a wish to that effect.

The question of the appropriate nature, in medical terms, of artificial nutrition and hydration in the terminal phase is itself a matter of debate. Some take the view that implementing or continuing artificial hydration and nutrition are necessary for the comfort of a patient in an end-of-life situation. For others, the benefit of artificial hydration and nutrition for the patient in the terminal phase, taking into account research in palliative care, is questionable.

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**Disputed issues**

**The question of limiting, withdrawing or withholding artificial hydration and nutrition**

Food and drink given to patients who are still able to eat and drink themselves are external contributions meeting physiological needs, which should always be satisfied. They are essential elements of care which should be provided unless the patient refuses them.
Special situations for palliative care
Withholding and Withdrawing

- Withdrawing or withholding a treatment that provides no benefit or has become disproportionate is from an ethical and a legal point of view the same.

- However it is to be emphasized that if a therapy is being stopped, standard care or palliative care - comfort - still has to be provided to the patient.
Withholding and Withdrawing

• Beauchamp & Childress accept those measures also for patients unable to consent, if
• the procedures are highly unlikely to improve nutritional and fluid levels
• The procedures will improve nutritional and fluid levels but the patient will not benefit
• The procedure will improve nutritional and fluid levels and the patient will benefit, but the burdens (…) will outweigh the benefits (physical restraints)

Remember:
A competent patient can refuse nutrition/hydration at any time
Voluntary refusal of nutrition and hydration

- Autonomous decision of a competent patient at the end of life
- legally and medically acceptable
- *Ultima ratio* in regard to the law or his religious views in a situation of unbearable suffering or very old age
- It is recommended to have an advanced directive
Primary Care Patients Hastening Death by Voluntarily Stopping Eating and Drinking


Cumulative survival curve for duration until death after start of Voluntarily Stopping Eating and Drinking (VSED) (Median time to death was 7 days).
Cultural Aspects & Religion

- increasingly multicultural and pluralistic society
- Respect for religion, ethnic groups and backgrounds?
- Limited knowledge of specific values and preferences
- Physicians and nurses own belief may be in conflict with clinical recommendations

Basic knowledge of different systems is mandatory
Should be obligatory in every curriculum!
Christianity

Catholic church

• General support, that every patient should receive nutrition and hydration, even artificially, as basic element of care
• But: Refusal of „overzealous treatment“ – due proportion in the use of remedies
Other aspects I

Protestant church
- Heterogenous, different approaches to end of life questions
- Importance of autonomy

Jewish Halacha
- Differentiation between active and passive acts (*withholding* & *withdrawing*)! as well as continuous treatments which have been started and may not be stopped.
- Artificial nutrition and hydration are basic needs and not a treatment
- Exception: it is permissible to withhold in the final days of life or according to the wish of a competent patient
Other aspects II

Islam

- Artificial nutrition and hydration are basic care and not treatment
- Principle of avoiding or minimizing harm is essential
- Starvation has to be avoided – it is viewed as greater harm than potential complications

- The decision of withholding or withdrawing AN&H from the terminally ill Muslim patient is made with informed consent, consideration of the clinical context, with input of family members, health care providers and religious scholars.
"Basic knowledge and skills in palliative care should become an integral part of all education and training programmes for medical doctors, nursing staff and therapists.

In pursuit of international role models, a post-graduate programme in palliative medicine should be established for these different education and training levels, thus strengthening the role of this discipline in the canon of medical education and leading to a significant improvement of healthcare."

*Dying with dignity, Austrian Bioethics Commission, 2015*
Thank you for your attention!

www.meduniwien.ac.at/bioethics
www.josephinum.ac.at
www.bka.gv.at