

Position Statement

Forgoing Nutrition and Hydration

Effective Date: March 11, 2011

Status: Revised Position Statement

Originated By: Congress on Nursing Practice and Economics

Adopted By: ANA Board of Directors

Related Past Action: Position Statement: *Forgoing Nutrition and Hydration*, April 2, 1992

Purpose: The purpose of this position statement is to clarify the role of the registered nurse in every healthcare practice setting pertinent to the support of patients and their surrogates deciding to provide or forgo nutrition and hydration.

Statement of ANA position: The American Nurses Association (ANA) believes that adults with capacity or, in the event of incapacity, their surrogates are in the best position to weigh the harms and benefits of nutrition and hydration as evaluated and discussed with them by the healthcare team. The acceptance or refusal of food and fluids, whether delivered by normal or artificial means must be respected. This belief is consistent with the ANA's expressed values and goals relative to respect for autonomy, relief of suffering and expert care at the end of life (ANA, 2001; ANA, 2010)

History/Previous Position Statements: The ANA Board of Directors first approved a position statement originating with the Task Force on the Nurses' Role in End of Life Decisions on April 2, 1992. The position statement was revised in 1995. Related actions include the Code for of Ethics for Nurses with Interpretive Statements, 2001, Guidelines on Withdrawing or Withholding Food and Fluid, 1988, and the ANA End of Life Position Statement, 2010.

Supportive Material: A key component of nursing care is the assessment and management of the nutritional needs of patients throughout the lifespan. Caring is a characteristic central to the profession of nursing. The rich symbolism of feeding is intimately linked to caring, signifying compassion, nurturance, and commitment. Social encounters, developmental memories, and human interactions center on events involving food and drink. The act of feeding and the act of providing fluids are concepts and actions closely tied to humankind's basic beliefs regarding care. Patients and their surrogates often look to nurses to help them understand their diagnosis, prognosis and treatment options in the context of their situation and in light of their values and beliefs. Conversations about family roles, benefits, options and goals of care may take place anytime an opportunity occurs. (Ersek, 2003; ANA 2010)

There is lack of data to support the effectiveness of artificial nutrition at the end of life or routine use of this interventions in severe dementia or other end-stage disease, and there are some data that suggest that nutritional interventions do not support improved clinical outcomes (Daly, 2000; Geppert, Andrews, & Druyan, 2010; Kirmer, 2003; Smith & Andrews, 2000). The patient or surrogate's right to forgo nutrition and hydration is well established. United States appellate court decisions, view the provision of artificial nutrition and hydration as medical treatment that can, like other treatments, be refused (Nelson, 1986; Cruzan v. Director, Missouri Department of Health, 1990; Schiavo v. Schindler, 2001). For this reason, the nurse's advocacy role is crucial to support patient autonomy and the right to forgo nutrition and hydration (Hospice and Palliative Nursing Association, 2003, 2004). When nurses have a moral objection to either the initiation or withdrawal of artificial nutrition or hydration, their objections whenever possible should be communicated in advance to provide safe alternate nursing care for patients and avoid concerns of patient abandonment (ANA 2001). Additionally, nurses should provide appropriate education and guidance for patients and their families on these and other end of life decisions (Ersek, 2007; ANA 2010). Ongoing assessments of the patient's decision making capacity is important and must be considered each time a decision is to be made. The principles of beneficence, nonmaleficence, autonomy, justice, the ethic of care guide nursing practice in the care of dying patients relative to forgoing

nutrition and hydration and the implementation of palliative care.

The Patient Self Determination Act of 1990 was a catalyst for discussions about written or oral directives in the face of incapacity. In response to this federal mandate, all fifty states have enacted a variety of forms of healthcare directives that allow adults with decisional capacity to appoint surrogate decision makers to accept or refuse treatment on their behalf should they become unable to make decisions. The directive allows the patient to document the direction of care in the face of terminal illness and incapacitation. (Omnibus, 1990). Advance directives are explicit indications of the patient's choices and values, thus advance directives, including those involving artificial nutrition and hydration, must be followed (Maillet, Potter, & Heller, 2002). These directives supercede the decisions of a surrogate. All the various forms of advance directives should be honored as the patient's direct wishes. In a Presidential Memorandum of April 15, 2010, President Barack Obama requested federal rulemaking to reinforce existing regulations – 42 CFR 482.13 and 42 CFR 489.102(a) – that “all patients' advance directives, such as durable powers of attorney and health care proxies, are respected” in all hospitals receiving Medicare or Medicaid funding (Fed. Reg., April 25, 2010).

Food and water offered to patients by mouth is the usual means of providing nutrition to patients. There are, however, situations in which nutrition can only be administered by artificial means. Artificial nutrition and hydration are incorporated into the patient's plan of care only when medically appropriate and consistent with the patient's beliefs, circumstances, and goals. Outcomes such as weight gain, increased caloric intake, or changes in laboratory test results do not themselves serve as adequate justification for this intervention. Such outcomes in the absence of any relation to overall well-being of the patient are not persuasive reasons to begin or continue to provide nutrition or hydration. Benefits and burdens of artificial nutrition and hydration must be discussed with patients and their families to enable them to make informed decisions. There is little research evidence to support either the premature cessation of hydration or continued hydration as a means to alleviate discomfort at the end of life. (Ersek, 2003)

When a patient or the surrogate has made a decision to forgo artificial nutrition and/or hydration, the nurse continues to ensure the provision of high quality care - minimizing discomfort and promoting patient dignity. When providing palliative care, the nurse supports and educates the family members of patients who are no longer receiving nutrition and hydration about comfort measures and the process of dying (Cimino, 2003). It is important to clarify the type and quantities of oral intake needed to provide comfort. Dying patients, whether at home or in institutions, typically have a decline in appetite and refuse even their favorite foods. Caretakers unaware of this phenomenon and concerned about maintaining "proper nutrition" need to understand that such a decline is normal and that efforts to ensure "good nutrition" are unnecessary and can be inappropriate in the context of palliative care (Schmitz, 1991; Matzo, Sherman, Newson-Marten, Rhome & Grant, 2004). Ice chips, sips of water and/or good oral hygiene as comfort measures should be continued even after decisions are made to discontinue artificial nutrition and hydration.

Definitions

Artificial Nutrition

"Artificial nutrition is any nonoral means of administering nutrition to a person. Methods encompass both enteral and intravenous (ie, total parenteral nutrition, TPN; also referred to as hyperalimentation) routes of administration. Enteral feeding is administered by tube via several routes: nasogastric, gastrostomy, jejunostomy, and esophagostomy." (Ersek, 2003, p. 222)

Artificial Hydration

"Artificial fluid therapy involves the nonoral delivery of fluid through one of the following routes: intravenous (via a peripheral or central line), subcutaneous (also called hypodermoclysis), rectal (proctoclysis), or enteral." (Ersek, 2003, p. 222)

Artificial Nutrition and Hydration (ANH)

Artificial nutrition and hydration are distinguished from the provision of food and water.

The provision of nourishment and hydration by artificial means (i.e., through tubes inserted into the stomach, intestine, or blood vessel) is qualitatively different from a person taking something by mouth and swallowing it or assisting with feeding.

Advance Directives

Advance directives are legal documents that allow individuals to make their preferences known regarding healthcare choices. Laws regulating advance directives vary from state to state (Nolde, 2004; Hospice and Palliative Nursing Association, 2004).

Surrogate

A surrogate decision maker, preferably designated by the patient, is one who makes decisions as the patient would or, when prior knowledge is insufficient for guidance are in the best interest of the patient and without self interest.

Palliative Care

Palliative care specializes in the relief of the pain, symptoms and stress of serious illness. The goal is to prevent and ease suffering and to offer patients and families the best possible quality of life. It is useful at any stage of an illness. And it can be used at the same time as treatment that is meant to cure you” (Center to Advance Palliative Care, 2007) <http://www.nlm.nih.gov/medlineplus/palliativecare.html>

Beneficence

Beneficence is the ethical duty of bringing about good (Purtilo & Cassel, 1981, p. 8). “Relieving, lessening or preventing harm and providing benefits and balancing benefits against risks and costs” (Beauchamp & Childress, 2009, p. 13)

Nonmaleficence

Nonmaleficence is the ethical principle that holds that the caretaker “avoid the causation of harm” (Beauchamp & Childress, 2009, p. 13).

Autonomy

The principle of autonomy upholds respect for the decision-making capacity of patients (Beauchamp & Childress, 2009, p. 13-14).

Justice

The principle of justice in the health-care environment has to do with the equitable distribution of benefits and services, as well as with fairness, which is understood as giving to each person that to which he or she has a legitimate right (May & Sharratt, 1994, p. 9).

The Ethic of Care

The ethic of care is a practice, not a set of rules and principles. Four elements of an ethic of care are attentiveness, responsibility, competence, and responsiveness (Tronto, 1994, p. 127). These elements of the ethic of care are further defined by the description of caring that emphasizes to care for, emotional commitment to, and willingness to act on behalf of persons with whom one has a significant relationship (Beauchamp & Childress, 2009).

Summary: The purpose of this position statement is to clarify the role of the registered nurse in every healthcare practice setting pertinent to the support of patients and their surrogates deciding to provide or forgo nutrition and hydration.

Adults with capacity or, in the event of incapacity, their surrogates are in the best position to evaluate the harms and benefits of nutrition and hydration following appropriate evaluation and discussion with members of the healthcare team..

Consistent with ANA expressed values and goals in the Code of Ethics for Nurses (2001) the acceptance or refusal of food and fluids, whether delivered by normal or artificial means must be respected.

References

- American Nurses Association. (2001). *Code of Ethics for Nurses with Interpretive Statements*, Washington, D.C., Author.
- American Nurses Association. (2010). *Expert Care at the End of Life Position Statement*, Washington, D.C., Author.
- Beauchamp, T. L., & Childress, J. F. (2009). *Principles of biomedical ethics* (6th ed.). New York: Oxford University Press.
- CFR Part 42 §482.13– Conditions of participation: Patient’s rights.
http://edocket.access.gpo.gov/cfr_2004/octqtr/pdf/42cfr482.13.pdf
- CFR Part 42 §489.102(a) – Requirements for providers.
http://edocket.access.gpo.gov/cfr_2004/octqtr/pdf/42cfr489.102.pdf
- Cimino, J. E. (2003). The role of nutrition in hospice and palliative care of the cancer patient. *Topics in Clinical Nutrition*, 18(3), p. 154-161. retrieved online
<http://gateway.ut.ovid.com/gw2/ovidweb.cgi> 2/21/2005
- Cruzan v. Director, Missouri Department of Health 58 U.S.L.W. 4916 (25 June 1990).
- Daly, B. J., (2000). Special challenges of withholding artificial nutrition and hydration. *Journal of Gerontological Nursing*, 26 (9), 25-31.
- Ersek, M. (2003). Artificial nutrition and hydration: Clinical issues. *Journal of Hospice and Palliative Nursing*, 5(4): 221-230.
- Geppert, C. M., Andrews, M. R., & Druyan M. E. (2010). Ethical issues in artificial nutrition and hydration: A review. *Journal of Parenteral and Enteral Nutrition*, 34, 79-88.
- Hospice and Palliative Nursing Association. (2003) Artificial nutrition & hydration: Clinical issues. *Journal of Hospice & Palliative Nursing*, 5(4), 221-230.
- Hospice and Palliative Nursing Association. (2004). Artificial nutrition and hydration in end-of-life care: HPNA position paper. *Home Healthcare Nurse*, 22(5), retrieved
<http://gateway.ut.ovid.com/gw2/ovidweb.cgi> on 2/21/2005
- Kirmer, D. (2003). Precepts of palliative care: “Managing nutrition and hydration while

providing palliative care." *The Kansas Nurse*, 78(10), 19.

Maillet, J. O., Potter, R. L., Heller, L. (2002). Position of the American Dietetic Association: Ethical and legal issues in nutrition, hydration, and feeding. *Journal of the American Dietetic Association*, 102(5), 716-726.

May, L., & Sharratt, S. C. (1994). Introduction. In *Applied ethics: a multicultural approach* (pp. 2-16). Englewood Cliffs, N.J.: Prentice Hall.

Matzo, M. L., Sherman, D. W., Nelson-Marten, P., Rhome, A., & Grant, M. (2004). Ethical and legal issues in end-of-life care: Content of the end-of-life nursing education consortium curriculum and teaching strategies. *Journal for Nurses in Staff Development*, 20(2), 59-66.

Nelson, L. J., "The Law, Professional Responsibility and Decisions to Forgo Treatment," Quality Review Bulletin, Joint Commission on Accreditation of Hospitals, January, 1986. Omnibus Budget Reconciliation Act of 1990, Public Law 101-508, Sec. 4207 and 4751.

Omnibus Budget Reconciliation Act of 1990, Public Law 101-508, Sec. 4207 and 4751.

Purtilo, R. B., & Cassel, C. K. (1981). *Ethical dimensions in the health professions*. Philadelphia: Saunders.

Schiavo v. Schindler, No.90-2908GD-003. (Fla. 2000).

Smith, D. A., & Andrews, M., (2000). Artificial nutrition and hydration at the end of life. *Medsurg Nursing*, 9(5), 233-244.

Tronto, J. C. (1994). *Moral boundaries: A political argument for the ethic of care*. New York: Routledge, Chapman, and Hall.

© 2011 American Nurses Association