CLINICALLY ASSISTED NUTRITION AND HYDRATION AT THE END OF LIFE

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Objectives

- Hydration and nutrition in the last days of life - guidance and evidence
- Ethical and legal considerations of hydration and nutrition at the end of life in clinical practice
- Discussing and assessing hydration with patients, family and staff at the end of life
Signs and symptoms at the EOL

- Reduced mobility - more bed bound
- Reduced level of consciousness/↑drowsiness
- Agitation and restlessness
- **Reduced appetite and decrease oral intake**
- Change in breathing
- Change in skin colour – mottled/cold
- Respiratory secretions
Nutrition & Hydration at the EOL

Are they allowed to eat and drink? If so, what can we give them? How much should we give them?

Their oral intake is poor, should we start them on artificial nutrition or hydration?

Should we refer them to the Dietitian due to their poor dietary intake?

Will they die in discomfort from hunger or thirst?

Are we affecting the dying process by giving / withholding food or fluids?

Should we be maintaining a nutrition care plan? Weight / MUST / food charts etc?

What do we tell the family when they ask what we are doing about their relatives poor food and fluid intake?

Is there any evidence available to support what we are doing?

Nutrition & Hydration at the EOL

The length of the dying process depends on which cells are deprived of oxygen – reducing organ function.

Weakness and fatigue - sleep more to conserve energy.

Changes in respiration, loss of sphincter control, reduction in blood perfusion and renal function.

Lose the desire to eat and drink – loss of appetite can happen weeks before last hours of life. There are many causes for this, most of which become irreversible close to death.

Loss of ability to swallow due to neurological dysfunction increasing risk of choking.

Gastric emptying, digestion and absorption and peristalsis decline. This reduces the body’s ability to be able to tolerate food.

What happens physiologically when we die?

Nutrition & Hydration at the EOL

- Hydration and nutrition were key issues with regards to the Misuse of the LCP & are key issues in the new NICE guidelines for the Dying Adult (2015)

- Perception of patients and family members that hydration offers
  - Hope: life sustaining, healing
  - Comfort: reducing pain, enhancing medications, nourishing, improving quality of life

- But can it prolong suffering?

Cohen et al, the meaning of parenteral hydration to family caregivers and patients, 2012
Definition: Clinically assisted nutrition and hydration

Artificial nutrition and hydration is the delivery of fluids and nutrition via an intravenous cannula (parenteral nutrition) or an enteral tube (Arenella 2005). Fluids may also be administered using the subcutaneous route. (Stiles 2013)


Nutrition & Hydration at the EOL - Ethical and Legal implications

• Basic care includes warmth, shelter, pain and symptom relief, hygiene measures and the offer of oral hydration and nutrition. It should always be provided unless actively resisted by the patient.

• Hydration provided by a tube or drip is regarded in law as a medical treatment.

CLINICALLY ASSISTED Nutrition & Hydration at the EOL - Ethical & Legal implications

- Hydration and nutrition is **ESSENTIAL FOR HUMANS**
- Families and doctors **FIND IT DIFFICULT TO WITHDRAW** clinically assisted hydration and nutrition up to the end of life of patient
- When nutrition and hydration become clinically-assisted, they are **CLASSED AS A TREATMENT** rather than basic care
- Hence as treatment when they cease to offer overall benefit, **THEY CAN BE WITHDRAWN**

Clinically Assisted Nutrition and Hydration (CAN/CAH)

The law does not distinguish CAN from any other forms of medical treatment. A medical treatment is started for a specific purpose and discontinued when failing to achieve or maintain this purpose. In patients where death is believed to be inevitable and where nutrition intervention is not considered to be of benefit, it can be withdrawn or withheld.

Cochrane reviews have examined evidence on the effects of CAN/CAH upon the quality and survival length of palliative care patients. To date there remains insufficient good quality trials to make any recommendations for routine practice. It therefore remains unknown whether this treatment helps people to live longer or feel better. Clinicians therefore need to make decisions based on the perceived benefits and harms of CAN/CAH in individual patient circumstances.

The debate

For artificial hydration

• Provides a basic human need
• Relieves thirst
• Prevents/treats uncomfortable symptoms - confusion, agitation
• Does not prolong life to any meaningful degree
• Provides minimum standards of care
• Prolonged dying phase (eg stroke) – can give intermittently according to need

Against artificial hydration

• Interferes with acceptance of terminal condition
• Prolongs suffering and the dying process
• Artificial hydration is intrusive and possibly painful, subcut
• Less oedema, pulmonary secretions, congestion, vomiting, and reduced need to pass urine
• Decreased levels of consciousness and suffering through production of natural endorphins
• Can reassess need

The evidence?
Known and unknowns?
Some...Known & Unknowns

- **RCP Oral feeding difficulties and dilemmas 2010, pp16-17**
  - Hydration without nutrition leads to death in 9-10 weeks in healthy, hydrated people
  - Removal of hydration may shorten this to 3 to 14 days
    - “giving hydration... may prolong dying”
    - “lack of hydration... accelerated the dying process”

- **Cochrane review**: Medically assisted hydration for adult palliative care patients (2008, updated 2011)
  - 5 studies (2 RCTs)
  - None looked at survival
  - 1 study: sedation and myoclonus improved
    - No significant difference in all other outcomes in all other studies (Sedation, myoclonus, fatigue, hallucinations, MMSE, thirst, nausea, delirium, anguish, agitation, bedsores, cognition)

- **Bruera et al, JCO 2013**: multicenter, double-blinded, placebo-controlled randomized trial – hydration vs placebo.
  - n=129
  - Intervention: 1L / day
  - All subjects were dehydrated
    - Did not improve symptoms, quality of life or survival
CANH
The GUIDANCE
CANH – GMC Guidance

- **Consider** the views of the patient and of those close to them
- **Explain** the issues – pros and cons
- Ensure all understand that CANH will always be considered if of benefit, and that if not of benefit, the patient will continue to receive high quality care
- If a patient is expected to die within hours or days, and you consider that the burdens of CANH outweigh the benefits, it will not usually be appropriate to start or continue treatment.
- 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.

GMC guidance (Treatment and care towards the end of life, 2010)
Advice & guidance

😊 Always offer food and drink – rarely do people need to be strictly NBM
😊 Take into consideration the personal and cultural preferences of the individual and their family
😊 Focus on personal choice, taste and tolerance rather than the nutrient content
😊 Encourage independence (OT, SLT, Dietitian)
😊 Small quantities are better tolerated – may only be a few mouthfuls or sips
😊 Provide help with eating and drinking
😊 Softer food consistencies may be better tolerated
😊 Sucking on ice lollies or ice chips may relieve a dry mouth
😊 Optimise the presentation of food and drink so that it looks good. Think about the size of plates, cups, crockery etc. to make eating/drinking easier
😊 Nutritional supplements are often unnecessary unless desired
The offer of food and drink by mouth is part of basic care as is the offer of washing, pain relief. It must always be offered to patients who are able to swallow without significant risk of choking or aspiration.

There is a genuine concern that dehydration accelerates death particularly in the elderly and frail where maybe their symptoms resemble dying.

We know that if you withhold fluids death usually occurs within 3-14 days.

Withholding food alone with adequate hydration death occurs within 57-90 days.

There is very little good quality research to answer this question.

Much of the research that is available particularly focuses on the use of clinically assisted nutrition and hydration (rather than food or drink by mouth) – but even with this research it is often not of good quality.

The majority of people who are imminently dying do so comfortably without the use of CAN/CAH. In the last days the lack of food or fluid will not contribute to the death rate.

Good communication with the medical teams, patient, family and carers is essential to ensure patients get the right care.
References

- Davies A, “Clinically Assisted Hydration at the end of life” Presentation at the Guildford Advanced Pain and Symptom Management Course (Manchester, 2013)
- Royal College of Physicians and British Society of Gastroenterology, Oral feeding difficulties and dilemmas: A guide to practical care, particularly towards the end of life (London, Royal College of Physicians, 2010)


• NICE guideline for The Care of dying adults in the last days of life: [https://www.nice.org.uk/guidance/NG31](https://www.nice.org.uk/guidance/NG31) (Dec 2015)
Thank you. Questions?