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Specialized Nutritional Support and its Ethical Issues

Apoyo nutricio especializado y sus implicaciones éticas

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Abstract:

The chronic condition of some pathology may lead the patient to a critical condition or even to an end-stage, putting the multidisciplinary group in an ethical conflict; as well as the family. Considering that the objective of healthcare staff has always been the well-being through prevention and correction of the clinical condition, avoiding, at all times, to relief pain and suffer, now having to address the therapeutic help to a "good death" of the patient. The cultural conditions have changed and death is not perceived the same way it used to be, nor by the society nor the group providing attention and care to the critical or end-stage patient, generating expectations for each case, separating the patient from reason and reality (1). Today, science has had a technological advance having a direct impact on the vital function of the patient, having a direct influence on the time, but mainly on the way of death, focusing the attention on the possible decisions of the seriously sick patient, starting the era of an "assisted death", as opposed to a natural death (1,2).

Keywords:

Palliative care, assisted death, vital support, critical and end-stage patient

Resumen:

El padecimiento crónico de alguna patología puede llevar al paciente a una condición crítica o incluso terminal, poniendo en un conflicto ético al grupo multidisciplinario que brinda atención; así como a la familia. Considerando que el objetivo del personal de salud, siempre ha sido el bienestar mediante la prevención y corrección de la condición clínica, evitando en todo momento el alivio del dolor y del sufrimiento, ahora teniendo que dirigir la ayuda terapéutica al "buen morir" del paciente. Las condiciones culturales han cambiado, y la muerte no tiene la misma percepción que hace algunos años ni en la sociedad ni en el grupo que brinda atención o cuidados al paciente crítico o terminal, generando expectativas ante cada caso, separándolo de la racionalidad y la realidad (1). Hoy, la ciencia ha tenido un avance tecnológico impactando de manera directa en el manejo de la función vital del paciente, influenciando de manera directa en el tiempo, pero sobre todo en la manera de la muerte; centrando la atención en las decisiones posibles del paciente gravemente enfermo, iniciando la época de una "muerte intervenida o asistida", por oposición a la natural (1,2).

Palabras Clave:

Cuidados paliativos, muerte asistida, soporte vital, paciente crítico y terminal

During the 19th and 20th centuries, death has been treated with caution, having a social connotation, even hiding it or considering it as a non-pleasant topic that should be avoided. The evolution of society behaviors regarding death, considers hospitalization to improve their condition. In the second part of the 20th century, the trend is to relief the pain and the symptoms associated to the death process, in such a way that dying at home was considered a death of poor people because of the fact that it happened without medical assistance.

Afterwards, with the technological development, there have been positions that question or suggest the intervention of the patient him/herself regarding the cares he/she wants to have during the death process, describing it as a "dignified death" (1,2).

The persistence and the presence of some or several clinical conditions put the patient in a precarious health

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situation, taking him/her to a sudden death. Today, these patients are classified in the following types:
a) the critical or dying patient, is the one that implies a high probability of death, it could even be expected within a few hours, due to the simultaneous failure or deterioration of organs or systems.
b) the end-stage patient, is the one with a deadly disease. This term should be applied only to those sick people that according to previous experience should die within a relatively short time, weeks more than months or years "without any hope" (3).

In the critical or dying patient, where death is always a threat, it has been discussed the concept of "letting die" with euthanasia, as opposed to "killing", suggesting a mistaken concept linked to the omnipotence of thinking and believing that the patient, a relative or even the healthcare staff itself can avoid death or decide on it, in these patients it is only possible to substitute the cardiac and respiratory functions (4)

The expression of "letting die" brings to mind the idea of abandonment and suggests the possibility of always being able to avoid death and forgets about the concept of futility (5).

To achieve this, it must be considered the use of the vital support, which is perceived from including mechanical ventilation, extracorporeal oxygenation or more complex situations like vasopressor drug therapy, chemotherapy, antibiotics or parental nutrition/hydration, even when they need less instrumentation, they have the same intentional meaning for the critical patient.

The vital support allows not only to substitute the function of an organ or system while treating a disease, but also allows to carry out procedures, treatments and surgical interventions to maintain the essential vital functions. However, it is common that the uncontrolled application of these procedures may lead to an unnecessary extension of agony and death, generating a misconception of medicine's objective, which is not mainly to avoid death but to promote health and to recover it in case of a disease. (6).

For that purpose, it is important to locate and identify the objectives of the interventions or of the vital support itself:

- Healing treatment: it is considered that hydration and nutrition are mandatory.
- Palliative treatment: it is important to consider life quality; therefore, hydration and nutrition may be possible depending on the life quality that is provided.
- Agonizing treatment: having on mind the life quality, hydration and nutrition are contraindicated (7).

Even though intensive and palliative cares have different priorities and objectives, they have common problems regarding the decision making and the appropriateness and inappropriateness of some medical actions in concrete situations.

According to the criteria and experience of experts in palliative cares, they have classified them into six ethical principles: sanctity of human life, therapeutic proportion, double effect, veracity, prevention and non-abandonment.

Identifying as main objective what is stated by the World Health Organization (WHO) which is the following:
- To reaffirm the importance of life, considering death as a normal process.
- To establish a process that does not accelerate nor postpone death.
- Provide pain relief and other symptoms relief
- Include the psychological and spiritual aspects of the patient's treatment.
- To offer a system of family support to face the patient's illness and cope with grief.

These objectives correspond to the conception of the so-called right to die with dignity, not as a right to die, but to a way of dying (8).

The administration of hydration and nutrition has been perceived differently in our culture, where it can even be considered as “killing for no providing food nor water". However, there is no appetite nor thirst in a critical or dying state. Nonetheless, there are other ways to provide that food, using the specialized nutritional support (9). The social perception of “providing food to hungry food or water to people with thirst” has a very high moral value. Eliminating these measures could generate guilt feelings, from both the family and the health care team.

The clinical practice identifies that artificial food and hydration are not comparable to other medical treatments, so its purpose is to never deny food nor liquids, therefore they are a crucial care, mandatory in every case. To this day, their application has not been defined as a palliative care because of the medical, familiar, religious, and social implications, so it is a topic in constant discussion.

Fears and myths, but mostly the culture together with an own opinion may generate incorrect information, however, the following points must be taken into account:

• Liquids are not the same as food.
• Dehydration does not mean suffering.
• Force-feeding a critical patient tires the patient.
• Eating cannot revert the underlying process.
• The loss of interest in food is a natural phenomenon close to death.
• The body only takes what it needs.
• Reducing food intake does not shorten life, it is simply a sign that the body cannot metabolize food anymore (10).

Some authors conclude that enteral and parenteral nutrition are part of the basic cares; others consider them a palliative or part of a palliative treatment, but very few take into account the will of the patient to use them. Therefore, it is considered that it must depend on the specific patient, respecting his/her will and evaluating the benefit they can bring to his/her life quality. If the death of the patient is imminent, they must not get started (11).

Decision making regarding the methods of vital support in these critical and complex cases, mainly involves establishing a limit in the health care attention that means no to apply or suspend treatments. The irrational use of these practices, results in a cultural confusion leading to act in every situation and doing whatever possible to preserve biological life.

Having before us a close death, makes you have a different perspective, it even violates the principles and values of the process of making the right decision, as well as its consequences, but above all, it makes you consider the patient’s will, in spite of his/her psychological condition, his/her autonomy and power of decision (8).

For all the previously mentioned, it is considered the use of bioethics, with the purpose of combining biological knowledge with that of human values. Today, there is a lot of technological development at the service of medical science, and it has motivated to make committed and controversial decisions. Today, the professional relationship between patient and doctor is defined as a social relationship, nonlinear, where the interaction must be seen from different perspectives: the patient, the health care staff and the institutions that represent the society, and also, the legislation. That is why the ethical clinical interaction tries to precise which are the obligations toward the patients, promoting a wide reflection between ethics and the making of therapeutic decisions at the end of life, making people discuss topics like euthanasia, therapeutic obstinacy, solidarity in death, the need of companionship, are crucial points of social debate. Today, decisions about vital support measures are common and discussed, as they have important consequences for the patient, his/her family and the society (12).

Under this context, two ethical aspects are considered that facilitate decision-making regarding nutritional support. The first one is related to the balance of the pros and cons of nutritional support and the patient’s desires. The other one refers to the destiny of economical, human and infrastructure resources.

In legal terms, courts have ruled in favor nutritional support being an intervention that may be accepted or waived by a competent patient or by a surrogate.

The debate must happen in a frame of “letting die” that, from a medical perspective, will tend not to stop the unavoidable surrender of vital functions, but will preserve the “right to die”, based on the patient’s autonomy, by rejecting treatments and choosing their life quality.

Finally, the patient has the right to ask for this nutritional intervention. Information about its benefits and charges must be given to the patient and his/her family; and, based on the informed consent form, he/she must accept the nutritional support (13).

BIBLIOGRAPHY

[1] Sociedad Española de Cuidados Paliativos (SECPAL). Guía de Cuidados Paliativos [monografía en Internet]. Madrid: SECPAL; [citado 4 jul 2009]. Disponible en: http://www.secpal.com/guiacp/guiacp.pdf

[2] Gracia D. La deliberación moral: el método de la ética clínica. Med Clin (Barc) 2001; 117: 18-23.

[3] Sorokin P. Análisis bioético del esfuerzo terapéutico en los pacientes críticos.Tesis aprobada para la maestría en Salud Publica de la Universidad de Buenos Aires. 1999

[4] Gherardi Carlos R. La muerte intervenida. De la muerte cerebral a la

abstención o retiro del soporte vital. Medicina (Buenos Aires) 2002; 62:279-290.

[5] Jonsen A.R., Siegler M. Winslade W.J. Clinical Ethics. 3rd.Ed. Mc.Graw-Hill 1992.

[6] Beauchamp T.L. Childress J.F. Principios de Etica Biomédica. Masson 1999 ; 270.

[7] Orgogozo JM, Dartigues JF, Lafont S, Letenneur L, Commenges D, Salomon R et al. Wine consumption and the elderly: a prospective community study in the Bordeaux area. Revue Neurologique 1997; 153: 185-192.

[8] Lavados M, Serani A. Suspensión y limitación de tratamientos. En: Ética

Clínica. Fundamentos y Aplicaciones. Eds. Univ. Católica de Chile, 1993

[9] Gherardi C.R. Encarnizamiento terapéutico y muerte digna. Mitos y realidades. Medicina 1998; 58: 755-762.

[10] Gracia D. La deliberación moral: el método de la ética clínica. Med Clin (Barc) 2001; 117: 18-23.

[11] Hopkins K. BAPEN Symposium 2: Nutrition in palliative care. Food for life, love and hope: An exemplar of the philosophy of palliative care in action. Proc Nutr Soc 2004; 63:427-429.

[12] Acreman S. Nutrition in palliative care. Br J. Community Nurs 2009;14(10):427-431.

[13] Del Cañizo Fernández-Roldán. La Nutrición en el paciente terminal. Punto de vista ético. Nutr Hosp 2005;20(2).