National Council for Hospice and Specialist Palliative Care Services

ETHICAL DECISION-MAKING IN PALLIATIVE CARE:
Artificial Hydration for people who are terminally ill

This paper has been prepared by a Joint Working Party between the National Council for Hospice and Specialist Palliative Care Services and the Ethics Committee of the Association for Palliative Medicine of Great Britain and Ireland.

The paper is concerned with artificial hydration by nasogastric tube, gastrostomy, or subcutaneous or intravenous drip. It should be noted that good practice suggests decisions regarding artificial hydration should involve a multiprofessional team, the patient, and relatives and carers, but that the senior doctor has ultimate responsibility for the decision. However, a competent patient has the right to refuse artificial hydration, even if it may be considered of clinical benefit. Incompetent patients retain this right through a valid advance refusal.

1. A blanket policy of artificial hydration, or of no artificial hydration, is ethically indefensible.

2. Towards death, a person's desire for food and drink lessens. Study evidence is limited (see References) but suggests that artificial hydration in imminently dying patients influences neither survival nor symptom control. As such it may constitute an unnecessary intrusion.

3. Thirst or dry mouth in people who are terminally ill may frequently be caused by medication. In such circumstances artificial hydration is unlikely to alleviate the symptom. Good mouth care and reassessment of medication become the most appropriate interventions.

4. Appropriate palliative care will involve consideration of the option of artificial hydration, where dehydration results from a potentially correctable cause (e.g. over-treatment with diuretics and sedation, recurrent vomiting, diarrhoea and hypercalcaemia).

5. It is a responsibility of the clinical team to make assessments concerning the relevance of hydration to the experience of individual patients. The appropriateness of artificial hydration should be judged on a day-to-day basis, weighing up the potential harms and benefits. The practicalities of appropriate provision will vary according to setting, but good practice will require that patients needing artificial hydration are transferred to a unit equipped to provide such care.

6. Relatives at the bedside of dying patients frequently express concern about lack of fluid or nutrient intake. Health care professionals may not subordinate the interests of patients to the anxieties of relatives but should, nevertheless, strive to address those anxieties.

The appropriateness of artificial hydration continues to depend on regular assessment of the likely benefits and burdens of such intervention