



Irish Association for Palliative Care

# **ARTIFICIAL HYDRATION IN TERMINALLY ILL PATIENTS**

Position Paper

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## Position Paper

### Introduction

The purpose of this paper is to examine the ethical issues relating to the role of artificial hydration in terminally ill patients. In this regard, we are concerned solely and exclusively with those patients whose life-expectancy is likely to be measured in hours or days.

The term 'artificial hydration' is used to describe the administration of fluids to patients who are unable to tolerate oral fluids by any of the following routes: intravenous, subcutaneous, nasogastric, gastrostomy or jejunostomy. A distinction is generally made between such 'artificial' means and ordinary means, as in the use of a cup or spoon to administer fluids orally to a patient.

### Principles

A competent, adult patient has the right to refuse artificial hydration, or to request its withdrawal, even if such a decision is likely to result in harm to that person or in his/her own death.<sup>1</sup> The Irish Association for Palliative Care endorses the right of the competent informed patient to refuse medical treatment.

Clinical and ethical decision-making becomes more difficult when a patient is incompetent and consequently unable to contribute to the decision-making process. If the patient has written an advance healthcare plan which covers the current circumstances, then the plan should be followed in accordance with the Irish Medical Council's Guidelines.<sup>2</sup> Healthcare professionals, in consultation with family members and significant others, have a duty always to act in the best interests of the patient.

Good clinical care does not involve the use of treatments that are excessively burdensome or futile. Doctors are ethically justified in withholding or withdrawing treatments that are not beneficial to their patients. In this context, it is important to remember that it is the benefits and burdens of the treatment that are under consideration. It is not appropriate to withdraw or withhold treatment because it is considered that the life of the individual is without benefit or is unduly burdensome. If a decision is made to withdraw artificial hydration, the intention "is to terminate not the life of the patient, but a form of care which has become incapable of serving its normal purpose" or which, "in seeking to serve that purpose, has become gravely burdensome".<sup>3</sup>

In the context of terminal disease, it is recognized that patients will continue to deteriorate as a direct and inevitable consequence of their illness. Also, it is recognized that dehydration has the potential to be an important cause of morbidity in seriously ill patients. Therefore, the onus rests with healthcare professionals to regularly assess the degree of hydration and the extent to which it might be contributing to a patient's deteriorating condition.

It is important to have an awareness of the situations where it may be possible to treat and reverse a clinical deterioration by the judicious and appropriate use of artificial hydration. These situations will include dehydration caused by hypercalcaemia, prolonged vomiting or diarrhoea, excessive diuretic use and sedation.

The fundamental clinical and ethical question that must be addressed is whether the patient is dying as a consequence of his/her illness or as a result of dehydration, or due to a combination of both dehydration and disease progression.

### Relationship Between Hydration Status and Patient Comfort

Many palliative care patients experience reduced oral intake during the last few days of their life. However, the use of artificial hydration at the end of life remains controversial. Previously, several authors have outlined both clinical and ethical arguments in support of and against artificial hydration in end of life care.

Arguments cited against the use of artificial hydration include: less urine results in less need to void or use catheters; less gastrointestinal fluid and less nausea and vomiting in patients who are not hydrated; fewer respiratory tract problems, such as cough and pulmonary oedema; and parenteral hydration is uncomfortable.

The arguments cited for the use of artificial hydration include: dehydration is a cause of renal failure, which can cause the accumulation of opioid metabolites resulting in confusion, restlessness and neuromuscular irritability; there is no evidence that fluids prolong life and parenteral hydration is a minimum standard of care.<sup>4</sup>

In 2008 a Cochrane Review looked at palliative care patients and the effect of medically assisted hydration on their quality and length of life. Only five relevant studies were identified, three of which showed no significant differences in outcomes between the two groups, whilst one study showed improvement in sedation and myoclonus

*The Irish Association for Palliative Care is the professional, multidisciplinary representative organisation for those engaged in, or who have an interest in, the provision of palliative care in Ireland.*

*Palliative Care is a person-centred discipline that has, as its ultimate goal, the achievement of the best possible quality of life for each individual patient facing a terminal illness.*

*This paper outlines the position of the IAPC with respect to Artificial Hydration in Terminally Ill Patients.*

in the intervention group and the other showed significantly higher symptoms of fluid retention in the hydration group. In short, the reviewers found that there were insufficient good quality studies to make any recommendations regarding the use of artificial hydration in palliative care patients.<sup>5</sup>

A more recent systematic literature review by Rajmakers *et al* of artificial nutrition and hydration in the last week of life in cancer patients was published in 2011. Fifteen papers were included in the review, of which fourteen related solely to the provision of artificial hydration. They found that whilst in many settings provision of artificial hydration was a frequent practice, there was little evidence that it improved symptoms or comfort.<sup>6</sup>

In the absence of consistent and convincing research data, the use of artificial hydration in terminally ill patients is more likely to be governed by established practice and culture, physician bias and place of care, rather than by any systematic, objective assessment of appropriateness.

Good clinical care requires all healthcare professionals to constantly monitor and assess the benefits and burdens of all treatments.

On the basis of available experience and published research as summarized above, it seems reasonable to conclude that artificial hydration in terminally ill patients who do not have a reversible cause for their clinical deterioration, is unlikely to confer significant benefit.

## Decision-Making Process

Palliative Care is concerned with the welfare of each individual patient in the context of his/her family.

Policies of always or never using artificial hydration are ethically indefensible. All decisions affecting a patient's care must be made on the basis of a set of circumstances unique to that patient.

Regular and clear communication with families is essential in the provision of end of life care, especially when discussing the potential benefits and burdens of any intervention.

If a patient is incompetent and unable to express his/her wish, the clinical decisions will only be made following consultation with other members of the multi-disciplinary team, and with the patient's family and significant others. In all circumstances, it is important to seek to reach a consensus that is in the best interests of the patient, and that is acceptable to all interested parties.

Understandably, when their loved one is dying, families may be concerned about the use or

omission of artificial hydration. Such views must be taken seriously and relatives need to be given an opportunity to voice their concerns and to receive appropriate explanations and reassurances. In some situations in end of life care, where it is uncertain if the potential burdens will exceed the potential benefits of artificial hydration, a time-limited trial of artificial hydration may be tried. However, healthcare professionals must not subordinate the best interests of the patient so as to relieve the concerns of the patient's relatives.

As healthcare professionals we are committed to making unprejudiced assessments of the relevance of artificial hydration for each individual patient in his/her end of life care.

In difficult clinical situations, it may be of benefit to an individual clinician to have the opportunity to discuss decisions regarding artificial hydration in end of life care with a local, clinical ethics committee, or with other healthcare professionals who have specific training, experience and expertise in the management of terminally ill patients.

IAPC Position and Discussion Papers are developed and written by the IAPC Ethics Working Group following wide consultation with the Association's membership.

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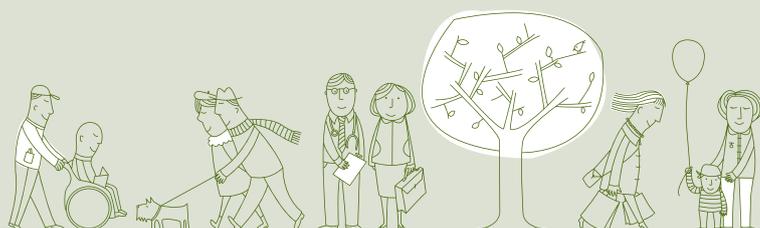
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Established in 1993, The **Irish Association for Palliative Care (IAPC)** is an all island body that exists to promote palliative care nationally and internationally through opportunities for networking, education, publications, and representation on national bodies.

As the sole membership organisation for those involved in the provision of palliative care, the IAPC is the primary collective and expert voice for palliative care in Ireland. Its mission is to drive national policy for patient-centred, equitable, accessible and accountable palliative care for all who need it.

A multi-disciplinary organisation, the membership reflects the multi-disciplinary team which delivers palliative care, and includes also those with an interest in the provision of palliative care.

Led by a Chairperson and Board of Directors elected by the Association's members, the IAPC is organized around a number of specialist fora and working groups. These groups provide individual disciplines with the opportunity to consider specific issues relevant to their own area of interest and expertise. The working groups are designed to create a forum for shared best practice and learning opportunities, and for members to further their professional development, education and research.

Current IAPC working groups include the Education and Research Forum, the Palliative Nursing Forum, the Ethics Working Group, the Children's Palliative Care Special Interest Group, the Palliative Care Pharmacists Group and the Palliative Care Social Work Group.

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