Guidelines on Withdrawing or Withholding Food and Fluid

American Nurses' Association Committee on Ethics

Is it ever morally permissible to withhold food or fluid from sick patients — and should nurses be involved in doing so? Under what circumstances might it be morally justifiable to withhold feeding from people who cannot speak for themselves?

Is it morally permissible to withhold food or fluid from sick patients — and should nurses ever be involved in doing so? The answer to these two related questions is No, under most circumstances, and Yes, in a few instances. The focus of these guidlines, therefore, is upon the *circumstances* under which it is morally permissible to withhold food and fluid.

The starting point for our understanding of what nurses ought to do is based on the general moral consensus of civilized societies, religions, and generations regarding the usual obligation to provide food and fluid to the needy, sick, and dependent who can be helped by it. Such an obligation is central to the common understanding of nurses' professional and moral duties.

An aspect of nursing care, as carried out regularly and routinely by all bedside nurses, is the provision of some form of food and fluid. Patients need food and fluid in order to feel better, physically and emotionally. The benefits of life and health from receiving food and fluid are so clear that, especially for those in the health professions (and perhaps most especially for nurses), there is a generally unambiguous moral duty to provide them. Thus, under most circumstances, it is *not* morally permissible to withhold or withdraw food or fluid from persons in their care, and nurses should not do so.

The most frequent instance when it is morally permissible, indeed obligatory, for nurses to withhold feedings are those occasions when patients would clearly be more harmed by receiving than by withholding feeding. Clinical examples include patients preparing for or just recovering from surgery, infants with such conditions as tracheo-esophageal fistula or anal atresia, and certain overeating disorders. These circumstances are temporary and usually involve substitute provision of specified nutrients. The goal is to provide proper nutrition later, when it is safe and beneficial. *Harm,* as used in this moral reasoning, is not simply synonymous with hurt, pain, or discomfort, though it may involve each. It refers rather to serious damage, often irrepairable, and involving the loss of valued capacities or pleasures. There are occasions when the provision of food and fluid is both painful and beneficial and the justification for the temporary imposition of some short-term discomfort from hunger and thirst.

Thus far, we have identified the two most ethically clearcut and common instances. First, nurses should almost always provide food and fluid because it is almost always an essential, life-preserving, health-giving benefit. Second, nurses should temporarily withhold food and fluid when their very provision clearly causes harm.

Ethical difficulties arise when it is unclear whether food and fluid are more beneficial or harmful. Since they are essential for life, this uncertainity ultimately leads to questions about whether life, under certain conditions, might be a greater harm than death. Determination of benefit and harm are further complicated by questions about whose evaluation of benefit and harm should be decisive. Should the evaluation by the patient, the family, the professional caregiver, a religious advisor, or that of society, through the court, predominate? There are also questions about whether possible harms and benefits to others, in addition to the patient, should be considered.

Since competent, reflective adults are generally in the best position to evaluate various harms and benefits to themselves in the context of their own values, life projects, and tolerance of pain, their acceptance or refusal of food and fluid should usually be respected. This ethical judgment is now well established legally[1,2] through various cases affirming the right of competent patients to refuse treatment, including food and fluid. It is morally, as well as legally, permissible for nurses to honor the refusal of food and fluid by competent patients in their care. The Code of Nurses[3], the historical evolution of nurses' professional responsibilities as patient advocates, and the general moral principle of respect for persons, sometimes referred to as the principle of autonomy supports this view.

It is important, however, to guard against the possibility that respect for a competent patient's right to refuse food and fluid could lead to indifference or a misplaced respect for patient autonomy. The danger, in this instance, results in nurses' failure to interest themselves in a patient's reason for exercising their presumed right. It is the patient's *reasons* which established the right and which, therefore, are pivotal in determining what the nurse should do. Moreover, because such serious harms to the patient are associated with the refusal of food and fluid (initial discomfort from hunger and thirst, illness, physical wasting, and ultimately, death), it is not enough simply to fulfill the obligation to respect the wishes of competent persons. Obligations to prevent harm and bring benefit also require that nurses seek to understand the patient's reasons for refusal.

First, it is important to establish clearly the patient's ability to understand her or his situation, the alternatives, and the associated harms and benefits. The refusal of food and fluid, however, is not itself evidence of incompetence. Patients who refuse based on their evaluation of life with severe physical constraints, or with intractable pain, or as a choice about way and time to die in the face of an eventually fatal illness, or as a last resort to draw attention to important social causes[4] will usually have weighed carefully the various harms and benefits associated with their refusal, in the light of their own values and capacities. Such reasoned reflection should be respected by nurses. Thus, in the case of competent patients with good reasons, "the patient" is the answer to questions about whose evaluation of benefit and harm should be decisive.

This answer should not, however, be taken automatically to apply to all circumstances of competent refusal. Competent patients can refuse for incongruous reasons. They may not have an accurate picture of the facts or they despair for reasons that are reversible, though they may not presently think this is true. These patients should receive special, sympathetic attention from nurses. Nurses should make every effort to correct inaccurate views, to modify superficially held beliefs and overly dramatic gestures, and to restore hope where there is reason to hope.

In certain instances, when a patient is no longer competent but it is possible to establish with certainty the patient's projected refusal, the same respect for a patient's values is indicated. Documents such as a living will, or other written or well-established verbal advance directives, or the legal assignment of a durable power of attorney[5] for healthcare, can be taken as aids in discerning the patient's view. The application of a previously stated refusal will, of necessity, require the judgment — both clinical and moral — of nurses and other

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caregivers as to whether the current situations is one to which the patient intended her or his refusal to apply. In general, advance directives, even those involving the withholding or withdrawing of food and fluid, should carry great weight in caregivers' discussions with the patient's family or surrogate. It is imperative, in this process, that nurses not substitute their own views about which lives are worth saving and living for the views of their competent or formerly competent patients.

In circumstances where the patient never has been competent (including infants, children, many mentally retarded persons, and the never competent mentally ill), nurses along with others have the moral and professional responsibility to decide whether provision of food and fluid is in the patient's best interest. The same moral and professional responsibility falls to caregivers in the situation of a patient who is not now competent, and where the patient's views, while competent, cannot be discovered. Patients who are incompetent make an *exceedingly vulnerable* population dependent upon caregivers for careful thought and compassionate action, including the provision of nutrition.

The withholding of food and fluid might be indicated only when feeding is futile because of underlying, incorrectable absorption problems; when it is itself severely burdensome to the patient or sustains life only long enough to die of other more painful causes. Only under very special circumstances is it morally permissible to withhold feeding or give less than adequate feeding to those who cannot speak for themselves. In such circumstances, the nurse's responsibility for care continues and special attention should be given to mouth and skin care, and other forms of compassionate touch.

If withholding food and fluid appears more harmful than expected, or if the patient's condition changes and hydration or nutrition appears potentially beneficial, the giving of food and fluid should be reinstituted. The views and moral sensibilities of caregiving family members should be influential in decisions for such patients unless there is clear indication that the family does not wish to be involved in decision-making or is not competent, or substitutes their own interests for those of the patient.

In almost all cases the provision of food and fluid is in the patient's best interest. For some, it is one of life's central pleasures. Rarely is feeding more burdensome than beneficial. In addition, the nurse's obligation to fulfill the duties of her office or profession and remain faithful to her patients includes the general role promise that the nurse will engage in activities that are nurturative, even when such care is not clearly beneficial so long as it is not harmful.[6]

Central to the benefit of life itself is the benefit of nourishment which sustains physical being and provides psychological or emotional comfort. Thus, even in circumstances where food and fluid do not provide adequate nourishment, it should be continued if it provides comfort. For example, infants with irreversible absorption problems still enjoys sucking and mouthing food, or older adults who have refused further renal dialysis may still derive pleasure from sips of fluids or bits of food despite their impending death. Feeding should not be continued or forced, however, when it is futile and when it inflicts suffering or harm that is not outweighed by an important long-term benefit.

The nursing profession believes that the social and economic responsibilities which result from this position should be shared by all citizens, not solely those with a family member in need of nursing. We further believe that the good conscience, security, and sense of well-being among citizens rests in part on the knowledge that the vulnerable will be nourished and that carefully considered refusals of food and fluid will be respected.

Footnotes

[1] Nelson, Lawrence J., "The Law, Professional Responsibility and Decisions to Forego Treatment," *Quality Review Bulletin,* Joint Commission on Accreditation of Hospitals, January, 1986, p. 8.

[2] Grant, Edward, R. and Forsythe, Clark, "A Plight of the Last Friend: Legal Issues for Physicians and Nurses in Providing Nutrition and Hydration," *Issues in Law and Medicine,* Vol. 2, No. 4, January 1987, pp. 279-299.

[3] American Nurses' Association. *Code for Nurses with Interpretive Statements.* Kansas City, Mo.: The Association, 1985.

[4] Suicide attempts as a prima facie refusal of life itself should not be taken as unquestionably entailing a refusal of food and fluid. Intervention to halt or reverse suicide rightly includes the emergency provision of food and fluid until the patient's reasons for the suicide attempt can be ascertained.

[5] A durable power of attorney is an individual's written designation of another person to act on his or her behalf, when the designation is authorized by a state's durable power of attorney statute. Under state law, a power of attorney terminates when the designating individual loses decision-making capacity, whereas a durable power of attorney does not.

[6] The Hastings Center. *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying.* New York: The Hastings Center, 1987, p. 57.

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Code For Nurses

1 The nurse provides services with respect for human dignity and the uniqueness of the client unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.

2 The nurse safeguards the client's right to privacy by judiciously protecting information of a confidential nature.

3 The nurse acts to safeguard the client and the public when health care and safety are affected by the incompetent, unethical, or illegal practice of any person.

4 The nurse assumes responsibility and accountability for individual nursing judgments and actions.

5 The nurse maintains competence in nursing.

6 The nurse exercises informed judgment and uses individual competence and qualifications as criteria in seeking consultation, accepting responsibilities, and delegating nursing activities to others.

7 The nurse participates in activities that contribute to the ongoing development of the profession's body of knowledge.

8 The nurse participates in the profession's efforts to implement and improve standards of nursing.

9 The nurse participates in the profession's efforts to establish and maintain conditions of employment conducive to high quality nursing care.

10 The nurse participates in the profession's effort to protect the public from misinformation and misrepresentation and to maintain the integrity of nursing.

11 The nurse collaborates with members of the health professions and other citizens in promoting community and national efforts to meet the health needs of the public.

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