Clinical Nutrition Open Science 47 (2023) 74–77

Contents lists available at ScienceDirect

Clinical Nutrition Open Science

journal homepage:
www.clinicalnutritionopenscience.com

Original Article

Commentary on the American Society for Parenteral and Enteral Nutrition (ASPEN) position paper: Ethical aspects of artificially administered nutrition and hydration

Stephanie Dobak [a], Mary Russell [b, *]

[a] Clinical Dietitian III, Jefferson Weinberg ALS Center, Philadelphia, PA 19107, USA
[b] International Clinical Ethics Section, American Society for Parenteral and Enteral Nutrition (ASPEN), Silver Spring, MD 20910 USA

ARTICLE INFO

Article history:
Received 7 November 2022
Accepted 7 December 2022
Available online 14 December 2022

Keywords:
Ethics
Artificially administered nutrition and hydration
Autonomy
Beneficence
Justice

SUMMARY

"Ethics is knowing the difference between what you have a right to do and what is right to do." -Potter Stewart.

In their position paper, "Ethical Aspects of Artificially Administered Nutrition and Hydration: An ASPEN Position Paper", [1] Schwartz *et al.* eloquently communicate key ethical concepts surrounding the care of patients receiving artificially administered nutrition and hydration (AANH). Ethically, all clinicians have the right and responsibility to provide nutrition-related access and resources to individuals in their care. At the same time, AANH is not always the right treatment to offer or provide.

This revised position paper, published in *Nutrition in Clinical Practice* (NCP) in April 2021 [1], is the work of the American Society for Parenteral and Enteral Nutrition (ASPEN) International Clinical Ethics Position Paper Update Workgroup. It represents a comprehensive update of the Ethics Position Paper of the ASPEN Ethics Position Paper Task Force, published in NCP in 2010. [2] The revised position paper includes a detailed discussion of important ethical considerations not covered in the 2010 paper: cancer and AANH, eating disorders and AANH, ethical considerations raised during the COVID-19 pandemic, and an international perspective on ethics and AANH. The position paper also references the Cartagena Declaration of 2019, which "stresses the recognition that nutrition care is a human right" [1,3] and comments that "extrapolating from this document, it appears to support resource allocation in a fair, transparent and consistent fashion" [1,3].

* Corresponding author.
E-mail address: peark02@outlook.com (M. Russell).

https://doi.org/10.1016/j.nutos.2022.12.002
2667-2685/© 2022 The Author(s). Published by Elsevier Ltd on behalf of European Society for Clinical Nutrition and Metabolism. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/).

This commentary summarizes the position paper and serves as a "call to action". All medical professionals can and should engage in ethical aspects of AANH. Roles may vary depending on professional discipline and setting, but each interdisciplinary team member provides critical value. We also strongly encourage all readers to engage in conversations surrounding the topic of AANH and ethics: disseminating the principles in the position paper via local, regional, and national conference presentations, journal club discussions, grand rounds, and within the fundamental educational preparation of all clinicians involved in nutrition therapy practice.

© 2022 The Author(s). Published by Elsevier Ltd on behalf of European Society for Clinical Nutrition and Metabolism. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/).

Introduction

Many clinicians are aware of the past ethical and legal cases involving artificially administered nutrition and hydration (AANH). Yet, robust nutrition education is still lacking in medical schools, and many clinicians feel overwhelmed and ill-equipped to navigate crucial conversations around end of life care [4–6]. What role do clinicians have in ethically promoting access to nutrition care and the fight against disease-related malnutrition? In addition, how do we differentiate what we have a right to do (and what we ought to do) and what is right to do? These discussions are often complex and include many concepts and characteristics (Figure 1).

Figure 1. Basic components and characteristics of ethical discussions. EBM, evidence-based medicine; QOL, quality of life; SDM, surrogate decision maker.

The “Ethical Aspects of Artificially Administered Nutrition and Hydration: An ASPEN Position Paper” offers practical insight into these questions. It uses evidence-based medicine, expert opinion, and clinical experience to guide clinicians as they assist patients/families/surrogate-decision makers (SDM) with ethical dilemmas surrounding AANH. We will summarize the position statements' practical guidance within the context of the four basic ethical principles.

Autonomy

Autonomy is the right of competent adults to make informed decisions about their healthcare. The position paper underscores the value of assisting patients with advance care planning, including the establishment of an advance directive and designation of an SDM. Informed decision-making requires clinicians to be honest, transparent, and open to questions during discussions about this care. The conversations are multi-faceted and not black and white. Patients are individuals, and each case is different. Clinicians must be respectful of preferences and quality of life goals, accepting patients' receptivity to AANH or modified-consistency food and liquids. Factors heavily impacting decision-making include cultural values, religious beliefs, ethnic background, and geographical considerations. It is not expected that every clinician be an expert in diversity. Translators and religious leaders are crucial resources in bridging language and religious differences, helping to ensure appropriate communication and the honoring of individual needs. Autonomy must be respected to the extent it is in concert with ethical principles and legal obligations. Disagreements arising between clinician obligations and patient preferences involving AANH should be acknowledged and discussed. Yet, conflicts may still exist. In these cases, the position paper encourages consultation with other providers and/or institutions, with coordination of transfer of care, to ensure individuals do not feel abandoned by the healthcare team. For those patients without an advance directive or designated SDM, the creation of a surrogate committee of bioethics committee members to offer input is encouraged.

Beneficence and nonmaleficence

Beneficence is the obligation of clinicians to act in the patient's best interest, and nonmaleficence is “do no harm”. We discussed that patients should have access to AANH if that is their desire, but what if receiving AANH is not in their best interest? Knowing what is medically best for patients requires knowledge of the impact and ethics of AANH in specific patient conditions. The position paper thoroughly reviews the following conditions: individuals suffering from coma, decreased consciousness and dementia; advanced dementia; cancer; eating disorders; and end-stage disease/terminal illness. Knowing this information, “clinicians should not be ethically obligated to offer AANH if, in their clinical judgment, there is not adequate evidence for the therapy or if the burden/risk of the intervention far outweighs its benefit.” [1] In the same vein, proper and timely diagnoses/prognoses are needed, particularly when disease-related malnutrition may occur. When the benefits of AANH are questionable, time-limited trials of AANH are encouraged once they are communicated and agreed upon by all parties. What happens when autonomy comes into disagreement with nonmaleficence? For example, patients suffering from eating disorders may refuse nutrition, yet AANH may be required to reverse resulting effects of life-threatening malnutrition. As the position paper states, there is a “delicate balance” between respecting autonomy and doing no harm when AANH becomes a nonnegotiable aspect of treatment.

Justice

Justice ensures the fair and equitable distribution of healthcare resources. How does justice manifest when resources are limited, such as in a pandemic or a manufacturing crisis? The position paper stresses the importance of adopting an ethical framework for allocating limited resources *prior* to potential shortages. These plans can alleviate stress when shortages occur, and action is needed. Planning and execution of those plans during shortages are a team effort. Planning involves education, including the need for regular diversity competency training within professional education. This training helps clinicians properly communicate with patients and understand their needs, which in

turn can help with timely distribution of resources. Triage committees and protocols should be established (in advance) to avoid ill perceptions or charges of inconsistent resource management. At the bedside, interdisciplinary teams must collaborate to define patient prognosis and the potential impact of AANH, assisting with the resource triage process.

While international ethical guidelines and practices are similar in many ways to those of the U.S., clinicians across the world must become and remain knowledgeable about specific details of and differences in laws and practices. The authors of the position paper strongly recommend further consideration and expansion of "The Troubling Trichotomy" of technology (what can be done?), ethics (what should be done?), and law (what must be done?) as proposed by Barrocas [7].

Conclusion

We congratulate and applaud the authors of the position paper for creating a detailed rationale and framework for applying the four ethical principles to decision-making involving the use of AANH. The paper serves as a comprehensive resource for employing a collaborative and interdisciplinary approach to help prevent and resolve ethical dilemmas. We maintain that by communicating with patients/families/SDMs at the bedside, serving on bioethics committees, creating institutional policies for resource allocation, and/or educating on diversity differences, every clinician contributes to the discussion and resolution of ethical challenges around AANH.

Author contribution

Conceptualization; Data curation; Formal analysis; Funding acquisition; Investigation; Methodology; Project administration; Resources; Software; Supervision; Validation; Visualization; Roles/Writing – original draft; Writing – review & editing. Please format with author name first followed by the CRediT roles:

Stephanie Dobak: Conceptualization, writing (original draft, review, editing), Mary Russell: Conceptualization, writing (original draft, review, editing)

Conflict of interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

References

[1] Schwartz DB, Barrocas A, Annetta MG, Stratton K, McGinnis C, Hardy G, et al. Ethical aspects of artificially administered nutrition and hydration: an ASPEN position paper. Nutr Clin Pract 2021;36(2):254–67. https://doi.org/10.1002/ncp.10633.
[2] Barrocas A, Geppert C, Durfee S, O'Sullivan Maillet J, Monturo C, Mueller C, et al. ASPEN ethics position paper. Nutr Clin Pract 2010;25(6):672–9. https://doi.org/10.1177/0884533610385429.
[3] Cardenas D, Echeverri S. Ethical aspects of the Cartagena declaration. Rev Nutr Clinica Y Metab 2019;2(Sup1):56–62.
[4] Tait V, Higgs M, Magann L, Dixon J, Davis JM, Fernandez R. Attitudes of nonpalliative care nurses towards palliative care. Int J Palliat. Care 2015;2015:1–6.
[5] Bergenholtz H, Timm HU, Missel M. Talking about end of life in general palliative care – what's going on? A qualitative study on end-of-life conversations in an acute care hospital in Denmark. BMC Palliat Care 2019;18:62.
[6] Schmit JM, Meyer LE, Duff JM, Dai I, Zou F, Close JL. Perspectives on death and dying: a study of resident comfort with end-of-life care. BMC Med Educ 2016;16(1):297.
[7] Barrocas A. The troubling trichotomy 10 years later: where are we now? Nutr Clin Pract 2016;31(3):295–304. https://doi.org/10.1177/0884433616629631.