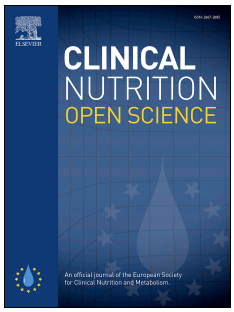

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ETHICAL DUTY, ETHICS AND RIGHT TO NUTRITIONAL CARE

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ETHICAL DUTY, ETHICS AND NUTRITIONAL CARE

ABSTRACT

Nutritional care has recently been recognized as a human right to promote access to optimal and timely nutritional care and help reduce disease related malnutrition. The patient who is endangered or suffering from malnutrition is highly vulnerable and at risk of having their human dignity affected. International declarations (of Vienna and Cartagena) have proposed and recognized nutritional care as an emerging human right, and the ethical duty of the nutrition support professional is to ensure access to it through care, responsibility, and justice. The purpose of this paper is to reflect the ethical implications of care, responsibility, and justice as foundations of ethical duty, the ethical implications of lack of access to nutritional care, and the possible solution in generating ethical awareness and education about nutritional care, based on the Vienna and Cartagena Declaration.

KEYWORDS: nutrition care, human rights, ethics, ethical duty, bioethics, malnutrition

INTRODUCTION

According to the Global Leadership Initiative on Malnutrition malnutrition is defined as a subacute or chronic condition in which a combination of varying degrees of under or overnutrition and inflammatory activity has led to changes in body composition and diminished function (1). The diagnosis criteria include phenotypic and etiologic changes as a consequence of the patient clinical conditions (2).

Malnutrition has been recorded since 1859 when it was observed that most patients were starving during their hospital stay (3). In 1974 it was identified in 61% of patients during hospitalization with an average weight loss of 6 kg, in addition to having no records of relevant data for the evaluation of nutritional status, and lack of medical approach to improve nutritional deficiencies (4).

Research has continued with similar results (5-8), and the most recent study in hospitalization worldwide showed a prevalence of malnutrition of 13% and risk of malnutrition in 19% with alterations in body mass index, involuntary weight loss and loss of muscle mass; more than 50% of admitted patients presented a decrease in intake before admission and low intake during their stay; and only 10% had nutritional therapy (9). However, malnutrition prevalence reports in a systematic review are high: in the range of 40-60% at the admission and it's known to increase according to the duration of hospitalization (6).Butterworth recognized that malnutrition is a tragic and iatrogenic problem due to approaches focused on the technological development of his time, which caused a lack of attention to the primordial need for food (4), which reflects an ethical and human problem. Currently it is known that nutritional intervention is 25% in patients who have had weight loss, less than 35% in patients who have had prolonged fasting and less than 20% in patients who consume less than half of normal (10), so it could be inferred that nutritional approach is not a priority.

Documents have been created to serve as a basis for the development of comprehensive strategies in the clinical setting to reduce the prevalence of malnutrition by ensuring nutritional therapy, combining scientific evidence with

ethical principles, human rights and medical education (9, 11-12), considering nutritional care (NC) as a fundamental tool for the prevention, detection, and treatment of malnutrition (12).

NUTRITIONAL CARE

Nutritional care (NC) can be considered as a process and as a human right. As a process it consists of 3 moments (12), its antecedent is "feedM.E." (11) and it is a response to the lack of knowledge of the malnutrition among health professionals. It is proposed as a human right (12) and is currently recognized as such in the Vienna Declaration (13), since it arises when the patient cannot have adequate access to the right to food and health because third parties are required to access them (14).

For this reason, health personnel should be aware that the patient is in a vulnerable situation with the risk of affecting the human dignity because the alteration in the capacity to eat and is at risk or suffering from malnutrition (15).

The ethical approach of the NC as a human right implies the ethical duty to ensure it in an optimal and timely manner with the available resources (13) by feeding the sick person in conditions of dignity, ensuring justice and equity (14), but what does the NC imply as an ethical duty? Why must justice and equity be considered in its exercise? What are the ethical implications of the lack of access to the NC in the clinical setting? These are the questions that will be analyzed to obtain greater clarity in the application of the NC, and to generate information that can be considered for future strategies that seek to safeguard the right to the NC.

NUTRITIONAL CARE: ETHICAL APPROACH

To speak about ethics is to refer to *ethos* as a way of being, the character, which is determined by the coexistence with other human beings that make up the community (16, 17), by sharing experiences, habits, practices and other vital situations. This influence the personal character depending on the environment in which it is being developed, and at the same time lead to assume responsibilities and obligations to the members of the same community (17).

Ethics plays a fundamental role in the development of the human being as an individual and, at the same time, in the recognition and acquisition of one's own duties and those of others, as shown in Kantian thought. Kant conceives duties as part of an ethical doctrine because they arise from the individual will and freedom. Therefore, ethical duty can be understood as an individual decision based on one's own freedom and will to fulfill a self-imposed end, while at the same time working on one's virtues and faculties (18).

If the ethical duty of the nutrition support professionals and the nutrition support team is to ensure the NC (13), it becomes a self-imposed obligation, because the problem of malnutrition is known, the vulnerability it causes and the risk of affecting the dignity of those who suffer from it; as well as the current actions to prevent and treat it (12, 13).

Ensuring access to NC implies having a high individual ethical development, because the objective is the care of the patient to reduce his vulnerability and protect his dignity, while at the same time seeking to be fair and equitable (14) through NC process. Care, responsibility, justice, and equity are part of the ethics to be

developed and therefore must be clear so that they can be the foundation of ethical duty.

The NC must be assumed in the practice by understanding it, feeling it and appropriating it (19), with the development of care and responsibility as basic individual *ethos*, since they are the foundation from the NC and the motivation to ensure it arise (20).

In the dietitians and the team of clinical nutrition, the *ethos* of care shows humanization through the actions and decisions (16), in addition to the to the ability to identify the needs of the other (the patient) (21) by having a development of sensitivity that recognizes the value of the human being by the simple fact of being (22), and identifying with the other (16).

On the other hand, the ethos of responsibility arises from care and helps to avoid harming human integrity (23), decreasing the vulnerability of the patient at risk or suffering from malnutrition, by ensuring NC as a process and as a human right. Responsibility implies a development of reason, which is possible with education and knowledge of scientific advances in the area (24), and at the same time sharing it with the health care team in which the patient is also found.

Along with care and responsibility, there are justice and equity, which, before being bioethical principles, must be virtues and duties to oneself (18). Virtues are not found in human nature but are exercised and reaffirmed at the moment of acting, and this is how they are learned.

If we must be just, then justice must be the virtue of the one who is exercising it, because it is the only one that includes all the virtues to seek the good of others or the common good, based on self-knowledge (18, 25), which in part is to know the rights and duties as human beings.

Justice is to give to each one what corresponds to, and in the case of the NC as a right, to be just is to know that every human being has the possibility of accessing it because it corresponds by nature. This also includes giving equal treatment to the patient, recognizing his right and seeking to ensure it by one's own moral law reflected in the other (21).

Justice understood as a bioethical principle and guide for therapeutic acts with respect to NC, must consider covering needs to avoid damage caused by scarcity (21), which means that the sick patient's need for NC must be covered to avoid the damage caused by not having access to it, which is the malnutrition, and when it develops, the patient can demand it and has the right to do so.

Along with justice there is also equity, which is related to fair opportunity, and can be defined as seeking that everyone has the same opportunity to access the services that allows them to fulfill their needs, which depends on the disadvantages caused by the problems they want to solve, which in this case would be the risk factors for developing or suffering from malnutrition.

But not all those who are at risk or suffer from it have the same causes or severity. Therefore, equity is what will allow taking the necessary actions in proportion to the problem for the distribution of resources (21, 25), so justice is also considered

distributive (21). When the NC process is carried out, it is possible to evaluate the burden of the affectation to the nutritional status according to its factors and, consequently, to decide which resources will be used and with what frequency, as well as the assignment of responsibilities within the multidisciplinary team.

Acting equitably means that decisions are made on the basis of rules that arise from the agreement of free and equal persons to reach an end with mutual respect (21), in this context it should be the decisions within the team to determine responsibilities, and to be able to ensure and exercise the NC with the patient, respecting the human dignity of the members of the team, including the patients.

With these ethical considerations, the development and criteria of the clinical nutrition professional will be able to fulfill his ethical duty, however, it is not enough to have this development, frequently, because many times the initiation of NC does not depend solely on the clinical nutrition staff.

CONSTRAINT: ACCESS TO NUTRITIONAL CARE

To ensure NC, there must be interdisciplinary teamwork involving physicians, nurses and nutritionists, among other professionals, each with specific responsibilities within the process, as individuals as a team.

Institutional organization can be a determining factor in the patient's access to NC. It has been observed that the lack of on-site clinical nutrition staff and the lack of protocols that include the NC process in patient care results in very few patients with access to it (26, 27, 28).

It has also been documented that access to NC depends on the treating physician and request for consultation (29). Referral to clinical nutrition is made within 61-71 days of the first medical consultation, which is considered a late referral for the clinical nutrition service (30). The longer the time of treatment and medical visits, the greater the possibility of requesting a consultation in the first year of care (31), decided by the physician, the patient, or the family member (30).

The limitations for requesting intervention are lack of knowledge to determine clinically significant weight loss, obesity, failure to recognize nutritional risk, inadequate screening (30, 31), poor understanding of the benefit of the nutritional approach (28), lack of knowledge of NC, lack of knowledge of malnutrition and its detection, lack of time or it is not considered a priority (32-36).

The barriers detected should be considered in order to propose actions and strategies to ensure access to NC and improve the quality of care services (35), but also to make it easier to establish responsibilities and the necessary training to perform the NC process.

The lack of knowledge of the malnutrition and of training to treat nutritional disorders of health personnel, recognized by themselves (28, 35-36), can cause damage that arises from ignorance, which generates negligence (37). This is how malnutrition and the lack of access to NC is aggravated, which is ethically unacceptable (4, 38), because it causes damage to human integrity and dignity, increasing vulnerability due to complications, risk of mortality and increased costs (4-6, 39-40).

By not ensuring the NC, an injustice is being done, since the right opportunity is not being sought to access it, especially because there is no clarity about the moment when they should be referred to clinical nutrition for the initiation of the NC process (37). At this point the patient's dignity is not respected, vulnerability is not considered, and neither is equity and justice sought to comply with the ethical duty.

This lack of action is not due to seeking to harm the patient; there is simply a lack of education and training to detect malnutrition or to implement NC (41), therefore, the risks are not known and, consequently, the patient's needs are not identified, running the risk of showing a careless way of being. In addition, the responsibility to procure NC is ignored due to lack of education and an overestimation of the knowledge of clinical nutrition, nutritional care and nutritional therapy (42).

As proposed by international statements, nutrition education in conjunction with the study of ethics (9, 12-13, 30) can begin to positively impact and help ensure nutritional care (37). In addition to education, there is also a need for greater support from the different health care areas to join efforts to ensure NC (35), to have the NC process performed by qualified and trained personnel to avoid biases at the time of screening, evaluation, diagnosis and treatment (30), to have availability of nutrition support professionals and nutrition support teams in hospitals and health care centers (28), and to know the nutritionists and the quality of their services (43).

CONCLUSIONS

To fulfill the ethical duty to ensure access to NC, it is necessary to consider the fundamental ethical aspects that should be part of the nutritional support

professionals and develop them in themselves, as ethical awareness, while educating health personnel to make the decision to refer the patient who is at risk or suffering from malnutrition or in need of nutritional therapy to the clinical nutrition service to begin their NC process. In this way, the human right to NC will be safeguarded, and access will be optimal and timely, showing the care, responsibility and justice that are the foundations of the human right and the creation of the NC process.

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CONFLICT OF INTEREST

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CONTRIBUTORS

Mónica López Talavera: conceptualization, reviewing, analysis, writing and editing.

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