Progress in Nutrition 2023; Vol. 25, N.2: e2023034 DOI: 10.23751/pn.v25i2.14592 Mattioli 1885

Focus on

Artificial nutrition and hydration: bioethical and biolegal profiles

Michele Ahmed Antonio Karaboue[1], *Michele Massaro*[1], *Giorgia Lacasella*[2]

[1]Department of Clinical and Experimental Medicine, University of Foggia, Foggia, Italy; [2]Department of Legal Medicine Department of Clinical and Experimental Medicine, University of Foggia, Foggia, Italy;

Abstract. The issue of artificial hydration and nutrition - NIA - shifts the focus to the duties that medical practice has to fulfil towards patients and their conditions. The need to adopt different forms of ethical evaluation, given the probabilistic and statistical nature of any clinical diagnosis, leads to different scenarios that ascribe immediate moral significance to human life, but at the same time link moral attribution (ethical or legal) to the subjective-existential dimension of the persons in whom that life is embodied. The choice of one point of view or the other seems to guide most current bioethical issues, such as the legitimacy of suspending medical treatments, the redefinition of the concept of health and its legal protection, and finally the definition of a new threshold between the "normal" and the "pathological". In this regard, some efforts lead to a shift, not so much epistemological as ethic-legal, of the state of vegetative state under the category of disability

Key words: NIA, nutrition, bioethics

In the field of artificial hydration and nutrition - NIA - our country is an almost unique exception in the world. In many countries it is considered a real medical treatment. In Italy, it has often been emphasized that the administration of water and food is always a natural means of preserving life (1) and not a medical act, even if it is done artificially. This latter position also found its way into the 2005 document of the National Bioethics Commission, in which it stated that NIA can never be a form of futile treatment per se, but that its suspension (2) should be understood as a request for euthanasia that is omitted as a result of the patient's abandonment, which is all the more serious when it concerns a state of disability (3) such as the vegetative state (4). Nutrition and hydration are the response to a basic need (5), not the treatment of a disease. A patient who cannot feed and hydrate himself is a disabled person who needs to be helped. Suppose he is deprived of hydration and nutrition. In this case, he will die of hunger and thirst, not of any disease he is suffering from: Unlike the interruption or denial of treatment, the interruption of hydration and nutrition is the cause of death (6) and constitutes true euthanasia (7) (in this case, an omission) (8), which is against our legal system and medical ethics. Of course, there are exceptions when even artificial hydration and nutrition (9) prove disproportionate or exceptional: Causing significant physical discomfort to the patient, excessive suffering or futility (inability to obtain nutrition and fluids). Nutrition and hydration are among the necessary measures of basic care (10) which must be granted to every sick person indiscriminately and regardless of their consent, since they have a modest technological content and, on the contrary, require a high level of human contribution. Article 37 of the Medical Professional Code states that in the event of a disturbance of consciousness, the doctor is obliged to continue life-sustaining treatment for as long as it is reasonably helpful and until irreversible loss of all brain functions, i.e., brain death, is established (11).

Consequently, in the case of patients in a vegetative state, in whom organic functions are not impaired, the discontinuation of nutrition would be the leading cause of their death (12): the cessation of nutrition

could therefore only be lawful (13) if there are exceptional forms of support, i.e., if the body is no longer able to absorb the supplied substances in the vicinity of death. In other words, the body does not have to be fed until it feels the need, but until it rejects the food of its own accord: In this way, the insurmountable limit of intervention in any case of a medical nature would lie in the physiological naturalness of the organism, where not the consent or the will of the patient (14), but life itself becomes the limit (15). Ultimately, only here does therapy become futility. Within this framework, hydration and nutrition are primary and appropriate forms of regular care that are just as ethically required as the provision of water and food for people who cannot care for themselves (children, the sick and the elderly). Maintaining the vital functions of a patient in a vegetative state does not require a high level of technical support because, although cortical death has occurred, he or she can continue to breathe independently through the minimal intervention of external hydration and nutritional support. In other words, according to this approach, we would be in the presence of sick people and people living with a disease, as vital functions do not seem to be affected. The administration of liquid nutrition via a nasogastric tube passed directly through the digestive tract seems to be a medically assisted way of delivering nutrients that is not very different from using a feeding bottle for an infant. However, this analogy seems unacceptable when applied to a clinical condition such as vegetative state, which has nothing ordinary about it. Infants and the elderly (16), while unable to feed themselves, feel hunger and thirst, demand water and food (infants from birth in a pretentious way) and refuse it when they are full. Even in the final stages of debilitation or loss of consciousness, the older adult opens his mouth, swallows when offered food, and closes it again when he no longer wants any. His body senses when he needs food and when he does not. None of this happens with a patient who is in a permanent vegetative state and is therefore force-fed nasogastrically or endogastrically (17).

Furthermore, it is problematic to consider a patient in a vegetative state as a form of disability where nutrition and hydration can be dutiful solidarity interventions and not medical treatments in the broader sense (18). The National Bioethics Committee felt it necessary to reiterate some basic bioethical principles from which a precise indication for feeding and hydration via tube or percutaneous enterogastrostomy would later emerge. From a legal perspective, it is generally assumed that not only all therapeutic and diagnostic measures (19) fall under the concept of medical treatment, but also all medical assessments (20) that have a direct impact on the subject's health (21) and the purpose of protecting it. In situations where the patient cannot express his or her will, the doctor must intervene (22), departing from the rule of informed consent only in cases where the law provides that medical treatments are compulsory. In other words, they may only be carried out compulsorily in cases where the legislature deems it necessary for them to be carried out without or against the consent of the persons concerned, while respecting the constitutional guarantees of personal freedom. However, the legislature can only make it compulsory if it does not violate certain conditions derived from constitutional provisions, which relate to the content and purpose of the health treatment. First of all, any treatment must be determined, i.e., provided for in sufficient detail in the law: The law can impose a duty on individuals to self-treat in relation to a specific disease or group of diseases, but not a general duty to maintain health, nor can it allow for a general duty to self-treat. This means that the duty of self-treatment, which derives from moral obligations, from responsibility towards other persons, can never be transformed into a legal obligation, since it is limited by the primacy that the Constitutional Charter (23) gives to respect for the freedom and dignity of the person (24).

Consequently, care must be taken in any compulsory treatment to ensure that it does not adversely affect the health of the person undergoing it (25-27). As far as NIA is concerned, the rule of the patient's voluntariness could be derogated from if the law provides for the compulsory nature of medical treatment in order to protect a fundamental community interest in the well-being of health. However, the justification for such compulsory treatment, albeit within the limits of the reservation of the law, would not lie in the protection of the general interest in the welfare of health, but in the welfare of life (28). It is only because it is a

question of protecting life and not health in general that one can observe the inversion of the relationship between the freedom to determine one's health and the restrictions on this freedom (29). To enshrine in law the defense of the patient's life at all costs would mean distorting the very meaning of compulsory treatments, whose legitimacy is only given when they are interpreted as an exceptional and deviant hypothesis of the principle of the total freedom of the person. In the sphere of life, elevated to the status of law and legal norms, the patient's decision and ultimately the quality of his or her health would be the exception (30).

Conflict of Interest: Each author declares that he or she has no commercial associations (e.g. consultancies, stock ownership, equity interest, patent/licensing arrangement etc.) that might pose a conflict of interest in connection with the submitted article

References

1. Baker J. A matter of life and deathJ Med Ethics 2017;43(7):427-434 .
2. Ferrato A. The new boundaries of therapeutic self-determination: The right to renounce artificial hydration and nutrition therapy. Archivio Penale 2019;71(3): ISSN 00040304.
3. Karaboue MAA, Milone V, Lacasella GV et al. What will our children do when we are gone? Italian legislature does not tackle the worries of parents of disabled children. Reflections on disability Med Histor 2022;6(1):e2022013.
4. Kitzinger C, Kitzinger J. Withdrawing artificial nutrition and hydration from minimally conscious and vegetative patients: Family perspectives. J Med Ethics 2015;41(2):157-60.
5. Lacasella GV, Karaboue K. A short history of human nutrition from prehistory to ancient civilisations Progress in Nutrition 2022;4(2): e2022135
6. Giaconi C, Manetti AC, Turco S, et al. Post-mortem computer tomography in ten cases of death while diving: a retrospective evaluation Radiol Med 2022;127(3):318-329.
7. Raspini M, Cavalcanti R, Clementini M et al. Periodontitis and italians (2016-2020): Need for clinical guidelines to perform effective therapy Dental Cadmos 2021;89(5):346-356.
8. Karaboue MAA, Lacasella GV, Cecannecchia C et al. End-of-Life in Italy: Critical and Bioethical Aspects of the Bill on Physician-Assisted Suicide Med Histor 2022;6(1):e2022026.
9. Bergstresser SM, Castellanos E. Feeding versus artificial nutrition and hydration: At the boundaries of medical intervention and social interaction. International Journal of Feminist Approaches to Bioethics 2015;8(2):204-225.
10. Jacobs BB, Taylor C. "Seeing" artificial hydration and nutrition through an ethical lens. Home Healthc Nurse 2005;23(11):739-42.
11. Pastorini A, Karaboue M, Di Luca A, Mario di Luca NM, Ciallella C. Medico-legal aspects of tort law patient safeguards within the Gelli-Bianco piece of legislation Clin Ter 2018;169(4):e170-e177.
12. Kapp MB. Life Sustaining Technologies: Value Issues. J Soc Issues 1993;49(2):151-6 .
13. Mazzariol B, Karaboue M, Di Luca A, Di Luca NM. Guidelines, good practices and best clinical health practices: Valuable guidance for physicians and judges? Clin Ter 2018;169(6):E292-E296.
14. Ciliberti R, Gulino M, Gorini I. New Italian law about end of life: Self-determination and shared care pathway. Recenti Prog Med 2018;109(5):267-271.
15. Cantisani V, Iannetti G, Miele V et al. Addendum to the sonographic medical act. J Ultrasou 2021;24(3):229-230.
16. Karaboue MAA, Ferrara M, Bertozzi G et al. To vaccinate or not: literacy against hesitancy Med Histor 2022;6(1):e2022014
17. Russo A, Reginelli A, Lacasella GV et al. Clinical Application of Ultra-High-Frequency Ultrasound J Pers Med 2022;12(10):1733.
18. Will JF. Dying with Dignity; Living with Laws (and Ethics) Hastings Cent Rep 2019;49(3):6-7.
19. Bernetti A, La Russa R, De Sire A et al. Cervical Spine Manipulations: Role of Diagnostic Procedures, Effectiveness, and Safety from a Rehabilitation and Forensic Medicine Perspective: A Systematic Review. Diagnostics 2022;12(5):1056.
20. Downie J. An alternative to medical assistance in dying? The legal status of voluntary stopping eating and drinking (VSED). Canadian Journal of Bioethics 2018;1(2):48-58.
21. Fiorini F, Granata A, Battaglia Y, Karaboue MAA. Talking about medicine through mass media G Ital Nefrol 2019;36(1):2019-vol1
22. Heuberger R, Wong H, Knowledge, Attitudes, and Beliefs of Physicians and Other Health Care Providers Regarding Artificial Nutrition and Hydration at the End of Life J Aging Health 2019;31(7):1121-1133
23. Palaia G, Bossù M, Pranno N et al. Oral Pathologies in Migrants: The Experience of the "PROTECT" Project in 3023 Patients Applied Sciences 2022;12(24):12621
24. Orzeszyna, K. The right to a natural and dignified death. Studia Iuridica Lublinensia 2020;29(4):221-232.
25. De Luca L, Veneziano FA, Karaboue M. Late Presenters with ST-Elevation Myocardial Infarction: A Call to Action. J Clin Med 2022;11(17):5169
26. Zanza C, Tornatore G, Naturale C et al. Cervical spine injury: clinical and medico-legal overview. Radiol Med 2023;128(1):103-112
27. Morena D, Delogu G, Volonnino G, Alessandrini S, Karaboue MAA, Arcangeli M COVID-19 Risk Management: a Survey among Italian physicians. Clin Ter 2023;174(2):167-179

28. Cappabianca P, Russo GM, Atripaldi U et al. Universal Access to Advanced Imaging and Healthcare Protection: UHC and Diagnostic Imaging. Med Sci (Basel) 2021;9(4):61.
29. Cioffi A, Cecannecchia C, Baldari B, Karaboue MAA Informal caregivers in Italy: the 'phantom zone' of welfare. Acta Biomed 2023;94(1):e2023018
30. Lacasella GV, Karaboue K. Nutrition and hydration of patients in a persistent vegetative state Progress in Nutrition 2022;24(2): e2022136.

Correspondence:
Michele Ahmed Antonio Karaboue, MD
Section of Legal Medicine
University of Foggia
Viale Europa, 12 - 71122 Foggia, Italy
E-mail: michelekaraboue@gmail.com