The ethical implications of artificial nutrition and hydration in end-of-life care: A comprehensive review

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Abstract. This article explores the multifaceted ethical dimensions of Artificial Nutrition and Hydration (ANH) in the context of end-of-life care. It delves into the debate over whether ANH should be considered a medical intervention or a basic human right, examining the symbolic significance of feeding and hydration in social and moral relationships. This work discusses the National Committee for Bioethics' standpoint on the moral obligation to provide food and fluids to patients in need, highlighting the complex interplay between medical necessity and ethical duty. This review also scrutinizes the classification of ANH as either a form of medical treatment or a basic human need, and its implications for decisions about initiating or discontinuing such interventions. Analyze the moral and practical considerations surrounding the suspension or non-initiation of ANH, emphasizing the importance of context and individual patient values in these decisions. The discussion underscores the dilemma faced by healthcare providers and caregivers in balancing the symbolic value of ANH against its clinical utility, especially in cases where prolongation of life might conflict with the patient's perceived quality of life. The article concludes by advocating for a nuanced, context-sensitive approach to ANH decisions, where careful ethical deliberation is paramount to ensure that the rights and dignity of patients at the end of life are respected and upheld.

Key words: artificial nutrition and hydration, end-of-life care, medical ethics, bioethics, patient rights, healthcare decision-making, moral obligation, clinical utility, quality of life, healthcare provider dilemmas

The status of Artificial Nutrition and Hydration is often found in biomedical literature, particularly in relation to the care of patients in a permanent vegetative state (1). A physician who withholds or does not initiate life-prolonging treatment is morally responsible for the patient's death (2). The fact that this conduct is morally justified refers to a judgment (3) on the disproportionality, extraordinariness, or futility of the treatment in question. Far from being objective, clinical, or technical, such judgment is implicitly moral and primarily concerns the patient's quality of life (4). Since the discontinuation of treatment is inseparably linked to the cessation of life, refusing a medical means, by suspending or not initiating it, implies acceptance that in certain cases, hastening death is preferable to prolonging life. This description of practical deliberation in end-of-life decisions makes the justification of abstention secondary to the Doctrine of Double Effect (5,6): the physician intends to honor a patient's request or suspend a futile means and foresees that this will result in the patient's death (7), but from a moral standpoint, it is the evaluation of the overall choice that matters. And the overall choice has motivational and ethical properties (8) not dissimilar to those of the choice to practice active voluntary euthanasia. Therefore, the suspension or non-initiation of Artificial Nutrition and Hydration in the case of a patient in deep and continuous sedation is only superficially an alternative to euthanasia. It falls within the same ethical perspective of dispositionalism. The only effective way to trace these distinctions is to correlate each notion with a corresponding deontic notion.

It can be argued that it is always mandatory to provide proportionate treatment, permissible not to provide disproportionate treatment, and obligatory not to provide futile treatment (10). The specification of related deontic notions has the merit of making more evident the moral principles that motivate the qualification of a treatment as proportionate, disproportionate, or futile (11). Sometimes even the initiation of Artificial Nutrition and Hydration may constitute a futile effort in attempting to prolong life, as the patient's clinical picture presents so many complications that death will occur shortly, regardless of the doctors' efforts. There seems to be no doubt that for these categories of patients, Artificial Nutrition and Hydration can also constitute avoidable treatments or even be obligatory not to practice them when they are not only useless (12) but also impose excessive pain or clinical complications. However, when such contraindications do not occur, it remains doubtful whether it is morally permissible to suspend Artificial Nutrition and Hydration (13). Many authors (14,15) argue that the association between sedation and the suspension or non-initiation of Artificial Nutrition and Hydration is not morally justified and that palliative care has gone too far (16) in deeming this end-of-life decision acceptable. This conclusion completely escapes the contextual nature of judgments on proportionate/disproportionate means because it maintains that the initiation or continuation of Artificial Nutrition and Hydration are morally obligatory in most cases where the patient is unable to feed (17) and hydrate themselves independently, except perhaps in cases where the use of these measures causes harm to the patient. Why are they morally obligatory? On one hand, the general idea persists that palliative care begins precisely when all treatments and efforts to defeat the disease have become futile. For this reason, it would not make sense to ask whether, at the moment when pain relief measures are adopted at the end of life, the medical treatments used are or are not futile (18). However, in recent years, there has been a reflection on the use of the notion of futility or disproportionality in palliative care, regarding the set of treatments that can prolong life (19). Regarding the specific nature of artificial nutrition and hydration, the recurring justification refers to the fact that Artificial Nutrition and Hydration are not actually medical means (20), therapeutic devices (21), and therefore are not subject to judgments of proportionality (22). Artificial Nutrition and Hydration are medicalized forms of aid and as such are owed to every human being, regardless of the specific context: they symbolize the fact that human life is inevitably social (23) and communal. Our interdependence, combined with our real experiences of hunger and thirst, makes this symbol even more powerful: hunger and thirst cause suffering, and we consider malnutrition and dehydration as severe forms of extreme agony. The duty to not suspend Artificial Nutrition and Hydration is a specification of our more general duty to not deny food and water to humans (24) who are hungry and thirsty, a fundamental foundation of human relationships. As recently reiterated by the National Committee for Bioethics, the moral duty to provide food and fluids to patients in need, even in borderline clinical conditions, derives from the common duty to provide water and food to those unable to procure it, such as children and the elderly. Fulfilling this common duty is a sign of a civilization characterized by humanity and solidarity (25) and an attitude that demonstrates the willingness to care for the weakest. Even when medicalized, nutrition and hydration should not be considered as medical acts (26). For their descriptive classification, the mode of administration is not as important as the purpose, which is to provide basic support to the needy and to allow life prolongation. Feelings of repugnance towards acts that cause deliberate death by starvation or thirst must be reinforced, and the interruption and non-initiation of Artificial Nutrition and Hydration risk achieving the opposite effect. Even in the medical context, relieving hunger and thirst is not only about respecting human rights and fulfilling duties (27) but also about the essential virtues of our moral life: the simple act of offering to alleviate the hunger and quench the thirst of a dying person is considered, across times and cultures, not only just but also good. However, beyond this, feeding means nourishing, in the inclusive sense of embracing [...]. This is perhaps the most elementary gesture of care, the one that persists even when the prospects for recovery are remote. While the symbolic value of nutrition and hydration in general and their function in preserving social and moral bonds (28) cannot be denied, the denial of the

morality of suspending Artificial Nutrition and Hydration based on these considerations does not seem entirely justified. The particular context in which Artificial Nutrition and Hydration are administered influences the moral value of their interruption or non-initiation. Certainly, it cannot be qualified as true "therapy", since it does not cure the patient or restore the spontaneity of the original function; for example, an antibiotic aims to eliminate a specific pathological state, while this is not the case with Artificial Nutrition and Hydration. From this perspective, it is similar to artificial respiration, i.e., technological treatments (29) that aim to substitute certain functions or capacities of the human body. When practiced in a medical context, Artificial Nutrition and Hydration are true medical treatments. Moreover, the nature of the solids and fluids administered is not properly assimilable to that of food and water as depicted when invoking their symbolic value. The categorization of Artificial Nutrition and Hydration as treatments implies that they are subject to judgments of proportionality. But clearly, it could always be argued that, even as medical treatments, Artificial Nutrition and Hydration always remain morally obligatory (30) precisely because of the particular symbolic value they acquire. These considerations are interesting in a defensive sense: they require careful and scrupulous evaluation of the decision to suspend or not initiate Artificial Nutrition and Hydration and to avoid passing from the judgment of licitness to that of duty. The risk that the right to refuse - by the patient, and to suspend or not initiate, by the physician (31) - this type of treatment becomes an obligation and a practice is high and can potentially undermine the moral foundations of society, given the high symbolic value of the practice. While there is no doubt that abuse in some cases is a consequence of the judgment of proportionality, it cannot be taken as an absolute reason to morally and legally prohibit the suspension or non-initiation of Artificial Nutrition and Hydration. Although scruple and attention are necessary, this applies to any decision to interrupt or not initiate a life-prolonging treatment (32). Moreover, concern for suffering, discomfort, and need is also manifested in other medical interventions, which symbolically can be traced back to helping those in difficulty and at risk of life. The decisions to suspend or not initiate such treatments essentially depend on the context and the judgment of the recipient of the medical intervention. The use of Artificial Nutrition and Hydration can sometimes be harmful to the patient and other times, as often happens in patients sedated continuously, can only aim to prolong a life judged by the patient as contrary to their interests and values. This is the fundamental point around which the judgment on the obligation or licitness of suspending or not initiating Artificial Nutrition and Hydration must revolve.

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