Ethics in Nutrition Care: Moving the Conversation Beyond End of Life Nutrition

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Objectives

1. Describe the principles of clinical ethics and how they relate to nutrition care (beneficence, nonmaleficence, respect for autonomy, justice and fairness).

2. Apply the principles of ethics to evaluate complicated issues in nutrition care.

3. Apply the 4-box method to assist in the ethical decision process for a nutrition related case.

Core Principles

Autonomy  Beneficence  Non-maleficence  Justice
4-box method

1. Medical Indications
2. Patient Preferences
3. Quality of Life Considerations
4. Contextual Features
1. Medical Indications

**Beneficence and Nonmaleficence**
- Medical problem, History, Diagnosis, Prognosis
- Acute, chronic, critical, emergent, reversible
- Goals of treatment and probability of success
- Plans in case of therapeutic failure
- How can this patient be benefited by care and how can harm be avoided?

What are the harms of nutrition therapy?
- (Artificial nutrition and hydration, diet counseling, medical nutrition therapy)

2. Patient Preferences

**Respect for Patient Autonomy**
- Patient mentally capable and legally competent? Evidence of capacity? If needed, who is the best surrogate, do they use appropriate standards for decision making?
- Is the patient informed of benefits and risks, do they understand the information, and have they given consent?
- What are preferences? Are they unable or unwilling to cooperate?

**Is the patients right to choose being respected to the extent possible in ethics and law?**
Quality of life

Beneficence, nonmaleficence, Respect for Patient Autonomy

Prospects with or without treatment to return to a normal life?

What physical, mental, and social deficits is the patient likely to experience if treatment succeeds?

Are there biases that might prejudice the providers evaluation of the patient’s quality of life?

Might the continued life be judged as undesirable?

Comfort or palliative care?

How is quality of life considered for diet and nutrition treatments?
(e.g. PEG placement, low sodium for heart failure, renal diets)

Contextual Features

Loyalty and Fairness

Consider issues with family and/or providers

Financial or economic factors

Cultural factors

Limits on confidentiality

Allocation of resources

Legal issues, clinical research/teaching issues

Other conflict of interest
### Story 1: Obesity

**Moral Framework**

<table>
<thead>
<tr>
<th>MEDICAL INDICATIONS</th>
<th>PATIENT PREFERENCES</th>
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<tbody>
<tr>
<td><strong>Beneficence and Non-maleficence</strong></td>
<td><strong>Respect for Patient Autonomy</strong></td>
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<tr>
<td>• What is the patient’s medical problem? History? Diagnosis? Prognosis?</td>
<td>• Is the patient mentally capable and legally competent? Is there evidence of capacity?</td>
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<tr>
<td>• Is the problem acute? Chronic? Critical? Emergent? Reversible?</td>
<td>• If competent, what is the patient stating about preferences for treatment?</td>
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<tr>
<td>• What are the goals of treatment?</td>
<td>• Has the patient been informed of benefits and risks, understood this information, and given consent?</td>
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<td>• What are the probabilities of success?</td>
<td>• If incapacitated, who is the appropriate surrogate? Is the surrogate using appropriate standards for decision making?</td>
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<td>• What are the plans in case of therapeutic failure?</td>
<td>• Has the patient expressed prior preferences (e.g., advance directives)?</td>
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<tr>
<td>• In sum, how can this patient be benefited by medical and nursing care, and how can harm be avoided?</td>
<td>• Is the patient unwilling or unable to cooperate with medical treatment? If so, why?</td>
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<table>
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<tr>
<th>QUALITY OF LIFE</th>
<th>CONTEXTUAL FEATURES</th>
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<tr>
<td><strong>Beneficence, Non-maleficence, and Respect for Patient Autonomy</strong></td>
<td><strong>Loyalty and Fairness</strong></td>
</tr>
<tr>
<td>• What are the prospects, with or without treatment, for a return to normal life?</td>
<td>• Are there family issues that might influence treatment decisions?</td>
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<tr>
<td>• What physical, mental, and social deficits is the patient likely to experience if treatment succeeds?</td>
<td>• Are there provider (physician, nurse) issues that might influence treatment decisions?</td>
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<td>• Are there biases that might prejudice the provider’s evaluation of the patient’s quality of life?</td>
<td>• Are there financial and economic factors?</td>
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<td>• Is the patient’s present or future condition such that his or her continued life might be judged as undesirable?</td>
<td>• Are there religious or cultural factors?</td>
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<td>• Is there any plan and rationale to forgo treatment?</td>
<td>• Are there limits on confidentiality?</td>
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<tr>
<td>• Are there plans for comfort and palliative care?</td>
<td>• Are there problems of allocation of resources?</td>
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<td>• How does the law affect treatment decisions?</td>
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<td>• Is clinical research or teaching involved?</td>
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<td>• Is there any conflict of interest on the part of the providers or the institution?</td>
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John is gaining weight

BMI > 50, hospital for 3+ months → Failing to respond to oral antibiotics and unable to place in SNF → Hospitalist is the primary care physician following patient

Pt would like to order from the pediatric menu → RDN put the recommendation in to order from the pediatric menu → Hospitalists did not follow the recommendation.

Medical indications
Autonomy
Quality of Life
Contextual
Moral frameworks

- Utilitarian: Benefit vs Harm
- Deontology (duty based): obligations to roll
- Principlism: focus on the core ethical principles
- Rights: avoid overriding someone’s right (autonomy focused)
- Virtue Ethics: focus on virtue, integrity, striving to ideals

How might the moral reasoning be different between the MD and the RDN? Could this be resolved....
Story 2: Caloric Restriction in Cancer Therapy

Patients desire to lose weight while undergoing cancer treatment

Maybe....
Fasting is thought to have cellular protection, partially mediated through a reduction in IGF-1 (and other growth factors) and reduces oxidative stress.
Increased life span in rodents, possible in humans.

Most of the research in done in animal models.

Risks.....
~15% body mass loss with a moderate restriction, coupled with cancer cachexia, may impair immune function and delay wound healing.

Is there evidence for fasting and caloric restriction in cancer treatment?
Mr T: Laryngeal Cancer with Partial Laryngectomy

BMI 38.9, HbA1C 10.7, taking metformin, insulin, and amlodipine

Nutritional needs were calculated (adjusted body weight) to be 35kcal/kg and 1.5g/kg protein

Recommendations were placed to meet these needs using a tube feeding formula through a PEG tube.

Over the following month, patient loosing weight and excited that blood glucose levels and hypertension are improving. Taking in <25% of needs.

Should a care conference with the patient and healthcare team be called to discuss low PO intake?

Is it ethical to consider emerging evidence in allowing patient to continue taking in less than needed?

Mr T: Laryngeal Cancer with Partial Laryngectomy

At 1 month (19% wt loss over past 5 months)—patient wants to continue using the PEG despite swallowing/chewing abilities being intact. Patient is excited about the weight loss and glycemic control.

Is it appropriate for the patient to keep the PEG when it is no longer needed swallowing/chewing difficulties? What options are available that are ethically appropriate?
Story 3: Tube Feeding in Dementia

Key Practice Points for Artificial nutrition and hydration

- No added value in the dying phase
- Limited values in patients with advanced dementia
- Temporary measure for patients in a comatose state
- No place in patients who choose to abstain from food and drink
- Symbolic, psychological, and social meaning of food and eating shouldn’t be underestimated, not ANH
74yo male, mental status changes, diagnosis of dementia, stopped eating.
Assumed mental capacity issues, Medical team contacted surrogate (niece) to get informed consent for PEG
Patient unresponsive to most providers, however stated he did not “want not be force fed like a goose” when asked about enteral nutrition.
Niece, surrogate, stated “but if he doesn’t have food, he’ll die”
Additional points to consider

Informed consent

- Decisional capacity
- Disclosure of information
- Comprehension of information
- Voluntariness of consent
What does informed consent mean for nutrition support?

How do you make sure families understand nutrition support and dissociate that from symbolic, psychological, and social meanings?

Autonomy versus beneficence

Consider personal values, progression of illness, and the burden of choice.
How do Emotional decisions impact decisional making capacity or consensus?

Goal is to have consensus based approach. Walk through diagnosis, prognosis, treatment benefits and harms.

Informed assent
Malnutrition

Ethics in health care systems

Hospital malnutrition

~50% of hospitalized patients experience malnutrition.
Administration of nutrition therapy is a medical treatment
Suboptimal feeding practices are common.
Ethical implications for hospital acquired malnutrition, RDNs should be empowered to educate other providers and administrators the importance of optimal nutrition therapy.
