

# Food and fluids in dying patients: some thoughts after the death of a patient.

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**Keywords:** Dying, terminal care, palliative medicine

## Summary

Death is inevitable but modern medicine has the skill and the facilities to delay its arrival. A case is made out for a radical rethink of the approach to the use of fluids and food in the terminal dying patient in hospital. (*SA Fam Pract* 2004;46(4): 06-07)

### Introduction:

As they approach death, many cancer patients are unwilling or unable to eat or drink much. Should they be left to eat only what they fancy or should they be encouraged to take more? If things really get bad, should hydration and nutrition be maintained by artificial means? This is a highly complex and controversial topic.

Think of the following scenario: A 32 year old woman is dying of advanced breast cancer. She has failed to respond to chemotherapy and all active anti-cancer treatment has been stopped. She is deeply jaundiced, confused, has grossly oedematous legs and a very swollen abdomen due to ascites. She is passing concentrated urine and has a dry mouth. Her medication includes a transdermal fentanyl patch and a mild sedative. She is taking small amounts of fluid and yoghurt by mouth. She has a 4 year old son and a very caring husband. What would you do?

Adding to the concerns of the doctor caring for such patients, is the uncertainty of the exact prognosis,

how long will she still live? How should you manage the last days of her life? What is the expectation of her husband, her parents and the nursing staff? What do you do if everyone doesn't agree on what to do?

Most doctors feel the need to "do something." Doing "nothing" sounds like neglecting a person in need and yet there is also a nagging fear that one's overzealous efforts may actually be prolonging the suffering of a dying person. Most people have a fear of an impersonal death stripped of all dignity in a high-tech setting with tubes emerging from every orifice, monitors beeping and one's family restricted to visiting hours only. Does dying with one's electrolytes in perfect balance compensate for all that?

In dealing with the dying person, comfort must be the prime goal. The risks, benefits and burdens of any proposed action needs to be carefully weighed up before embarking on any course of action.<sup>1</sup>

### Ethical issues:

Food and fluids are such basic necessities for life, such strong symbols of care and love, that many people and even some doctors would suggest that to deny them to a dying person is a form of neglect, euthanasia or worse still, even torture.<sup>2</sup> As one man said to me, "I don't mind my mother dying of cancer but I don't want her to starve to death."

While we all accept that death is inevitable, modern medicine has the skill and the facilities to delay its arrival. By means of central lines and hyperalimentation we are able to "feed" someone even if he/she is unable to take anything by mouth. Should such means be used to sustain the lives of dying cancer patients?

What if such heroic measures fail? If one starts along the route of active intervention, is it ethically justifiable to discontinue the IV infusion, remove the NG tube and turn off the ventilator?

Does an individual have the right to refuse such treatment? Should we be encouraging more patients to draw up an advanced directive (Living Will)? Should we be looking

at providing a more humane alternative to the overmedicalized nightmare described above? While there are no easy answers, I believe there are options which are both ethically sound, medically appropriate and patient friendly.

### The Process of Dying:

It may be helpful to briefly review the process of dying. Many cancer patients develop weight loss, lethargy, weakness and increasing immobility. Reduced food intake causes reduced gastric contractions and leads to reduced hypothalamic stimulation and anorexia. With the lack of glucose and protein from the diet, the body will turn to the metabolism of fat stores. The resulting raised ketone levels further suppress hunger and thirst. The use of fat as the main energy source may lead to the sparing of muscle breakdown, greater endogenous water production and a reduced need for fluid intake. Diminished urea production means that less water needs to be excreted by the kidneys.

Eating may actually reverse this metabolic process and may cause increased hunger, thirst and muscle breakdown. Some studies have even shown reduced survival in those on more aggressive nutritional support due to the complications of therapy and possible enhanced tumour growth.<sup>3</sup>

McCann and colleagues from Rochester University (NY) investigated the frequency of symptoms of hunger and thirst in dying patients and whether these could be relieved without the use of forced feeding or parenteral nutrition. They found that 63% never experienced any hunger, while another 34% only had mild symptoms initially. Similarly, 62% experienced no thirst despite grossly inadequate fluid intake. All of those who did experience symptoms, could be made comfortable

with sips of water, sucking crushed ice and lubrication of lips. Patients only ate when they felt like it. Those patients who ate more to please their families, experienced increasing abdominal discomfort and nausea.<sup>3</sup>

"Unwanted nutritional support and hydration though intravenous or enteral routes may not only be ineffective in reducing morbidity in advanced cancer, but may even be associated with an increase in medical complications and reduction in quality of life."<sup>3</sup>

In a study looking specifically at dehydration and the dying patient, Ellershaw demonstrated that thirst and a dry mouth were not proportional to the degree of dehydration but were often due to local causes or prescribed drugs. In such cases artificial hydration would be futile.<sup>4</sup> The National Council for Hospice and Specialist Palliative Care Services of Britain in a policy document concluded that as artificial hydration neither improves survival nor symptom control, it may even constitute an unnecessary intrusion.<sup>5</sup>

Dying is seldom easy. It evokes strong feelings and sometimes very negative emotions. As death approaches, patients often withdraw and may seem depressed. Many terminal patients become delirious. Surely this is due to dehydration? Surely parenteral fluids would correct this? The available evidence, however, does not support this approach.<sup>6,7</sup> Apart from occasional nausea, the gradually developing dehydration of the dying cancer patient appears to be remarkably asymptomatic. In addition there are several disadvantages of parenteral hydration. Increased urine output may result in incontinence or the need for an indwelling catheter. IV

canulas are uncomfortable and can cause infection. The drip impedes mobility and creates a barrier to the family and makes nursing more difficult. It may also create the wrong impression about the patient's chances of recovery. Care gets focused on the drip rather than on the patient. Increased respiratory secretions may cause a troublesome 'death rattle'. Fluid overload may precipitate pulmonary oedema.

### Conclusion:

Let us briefly return to our patient. She was cared for at home. Her general condition gradually deteriorated. With the reduced intake of fluid, her oedema and ascites subsided substantially, and she did not require a catheter. Careful mouth care and spraying regularly with water kept her oral mucosa moist and comfortable. She died peacefully at home without the need for a drip or artificial feeding.

I believe a strong case can be made out for a radical rethink of the approach to the use of fluids and food in the dying patient in hospital. "A doctor has neither a duty nor the right to prescribe a lingering death."<sup>8</sup> ♡

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