Tube feeding dilemmas: can artificial nutrition and hydration be legally or ethically withheld or withdrawn?

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INTRODUCTION

The ethical and legal issues concerning artificial hydration and nutrition is becoming increasingly significant to nurses involved in caring for the elderly. Approximately 2 years ago the small community hospital, where the author worked, received its first elderly patient with a percutaneous endoscopic gastrostomy (PEG) tube. The insertion of a small feeding tube directly into the stomach through the abdominal wall is increasingly used to maintain hydration and nutrition in patients who have been left with impaired swallowing resulting from a cerebrovascular accident (CVA), or stroke. Indeed the succeeding months saw a steady stream of such patients through the hospital. Managing stroke victims in this manner is not supported by all physicians, as the outcomes for these patients vary, and poor quality of life is often the result.

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Getting the therapeutic ratio right (balance of benefit over harm) in this situation might be impossible to achieve for all, since in the early days following a CVA it is not always possible to predict the extent of physical and intellectual impairment.

Advances in medical knowledge and technology enable the medical profession to exercise greater control over life and death. However, being able to prolong life in some cases may be in conflict with the ethos of caring, which has at its core, empathy for others and the relief of suffering. People may now live longer suffering from chronic debilitating conditions, supported by medical technology that does nothing to relieve or treat the underlying condition or to improve quality of life. Invasive treatments can further reduce quality of life through pain and discomfort, loss of dignity, and ensuing complications. Artificial nutrition is an example of an invasive technological advancement that has created new opportunities, not only for improved patient outcomes, but also increased length of survival. Undoubtedly, it has a valuable role to...
play in the outcomes for acutely ill patients who are unable to take fluids or food for a short period of time. However, the wisdom of administering long-term artificial nutrition to every patient who can no longer eat independently is debatable (Peck et al. 1990, Meyers & Grodin 1991, Hodges & Tolle 1994). A survey of 1400 doctors and nurses by Solomon et al. (1993), revealed that almost half had concerns about the inappropriateness of the provision of artificial nutrition and hydration in dementia patients and the terminally ill.

Tightrope
Those involved in the decision-making in these circumstances walk a tightrope between overtreatment and neglect. It is in situations like this that health care professionals need to be aware of, and understand, their own ethical decision-making if they are to defend themselves morally and legally. Adequate hydration and nutrition are prerequisites for life and the cessation of either leads to death. Consequently their non provision has serious legal and ethical implications. This paper examines the ethical dilemmas and legal implications of actions or omissions concerning artificial hydration and nutrition, and attempts to answer the question ‘can artificial nutrition and hydration be legally or ethically withheld or withdrawn?’

The legal implications are considered first, however, it is important to note that law and ethics are closely related and can not exist in isolation of each other, the values and beliefs of a society forming the moral basis for its laws.

The law related to health care is in a continuing state of development as medical negligence suits heard in the civil courts cause the legal profession to examine and judge the ethical decisions surrounding patient care. In doing so, legal precedents are set which serve to guide judgment in future cases. The setting of a legal precedent in this way is a feature of English law called case law which enables judges to base their rulings on standards set in previous cases and make consistent judgments in forthcoming cases. However, not all decisions will be binding in future cases, and in order to set a precedent, the case needs to be heard in a sufficiently high court. Case law, then, serves as an indication, but is not necessarily a guarantee of how subsequent cases will be dealt with.

TONY BLAND CASE
In recent years, several cases have been heard in the courts related to artificial nutrition, and these can offer health care professionals some clarification of their position in these situations. Of these cases, the most significant for nurses was that of Airedale NHS Trust v. Bland (1993). The Tony Bland case was heard in the highest court, the House of Lords, which has the authority to overrule decisions made in lower courts and create binding precedents on future similar cases. Its significance for nursing was in its clarification of artificial feeding, defining it as a treatment rather than nursing care. Tony Bland, a victim of the Hillsborough disaster, was comatosed and in a persistent vegetative state (PVS) for 3 years. In 1993, his parents applied to the courts to have artificial nutrition withdrawn. The court ruled that as Bland was not expected to recover, the treatment was of no benefit to him, so the medical team had no duty to continue with the treatment. Furthermore, as he no longer had any interest in living, having no higher cognitive function, it was not in his interests to have his life prolonged.

Elderly people
The precedent set by the Bland case indicates that a medical team can legally consider withdrawing artificial nutrition and hydration if certain conditions prevail. The risk of prosecution in these circumstances, although not eliminated, has been greatly reduced. This case, however, can only guide decision-making concerning PVS patients. There have, to date in this country, been no test cases for the withdrawal or withholding of fluid or nourishment by artificial means in patients other than those who are deemed to be brain dead, or in Tony Bland’s case, in a persistent vegetative state. Neither of these two classifications of patients describe the situation of the increasing number of elderly patients whose life is maintained by artificial nutrition and hydration. Some of these elderly patients, however, share a characteristic with PVS patients, namely, loss of self-determination, or autonomy. This loss of autonomy in the elderly is commonly caused by dementia or brain damage resulting from cerebrovascular accidents (CVA) and, if severe enough, render patients incapable of making decisions about what is in their own best interests.

Requests for termination of artificial nutrition and hydration in non-autonomous elderly patients, other than those who are deemed brain dead or in a PVS, have been made to the courts in other countries. However, it must be remembered that the details of the law differ between countries, and a judgment in one cannot automatically be transferred to another. Such a case is that of Conroy v. New Jersey Supreme Court (Hodges & Tolle 1994). The Conroy case involved an elderly, severely demented woman, who was discharged from hospital to a nursing home with an enteral feeding tube in situ following pneumonia. Her nephew, who was also her legal guardian, requested a court order for the removal of the tube because he did not believe she would have wanted it. The New Jersey Court ruled that ‘life sustaining therapy could be withdrawn if it would be in the incompetent patients best interests, which is to say that the pain and suffering from continued living outweigh the benefits of prolonging life with artificial nutrition.’
RIGHT TO SELF-DETERMINATION

The principle that every autonomous person has the right to self-determination or self-rule has led to the legal doctrine of informed consent, which gives people the right to accept or refuse treatment. The legal profession recognizes that non-autonomous patients cannot exercise those rights, so they have allowed responsible caring surrogates, usually family members, to make decisions about treatment. However, there is a risk that the surrogate may not act in the patient’s best interests, and if likely to benefit financially from the death of the patient, may be motivated by self-interest. A way in which non-autonomous people can safeguard their interests is to make an advance directive, or living will. This involves nominating a surrogate or indicating treatment preferences whilst still competent.

Advance directives are advocated by the Voluntary Euthanasia Society and, although their aim is to allow non-autonomous patients to retain some control over their fate, they are not legally binding, serving only to guide rather than dictate medical decision. This is because advance directives are written with limited knowledge and insight into medical conditions and treatment options, and so do not equate with the legal doctrine of informed consent, which requires the giving of sufficient information to allow informed choices to be made.

Support for autonomy

The law has demonstrated that it supports the rights of autonomous patients, and also non-autonomous patients through proxy or advance directive. It also supports medical decisions on the grounds that the treatment is against the person’s best interests. Comments made by judges such as:

A competent person has the right to decline any treatment, including artificial feeding, and should retain that right when and if he becomes incompetent.

(Conroy v. New Jersey Supreme Court 1985)

and

... the burden of maintaining corporeal existence degrades the very humanity it was meant to serve.

(Brophy v. New England Sinai Hospital 1986, Weir & Gostin 1990)

indicate a patient-oriented reasoning that does not require doctors to preserve life when the burden of life is overwhelming. These judicial trends suggest that doctors have little to fear in the legal arena when withholding or withdrawing treatment if the clinical judgment is made in the patient’s best interests, or if acting in good faith on the wishes of family members, or on previously expressed wishes of the patient.

In contrast, doctors may be at risk of litigation for overtreating patients when the treatment was not wanted by the autonomous patient, contrary to the best interests of the non-autonomous patient or against the wishes of his family. Two examples of four such cases quoted by Weir & Gostin (1990) are: Estate of Leach v. Shapiro (1984) and Elbaum v. Grace Plaza (1989). In the former case, the court ruled that the ‘unwanted, nonemergency treatment (including a ventilator and nasogastric tube) given to a patient in a vegetative state for several months represented a battery for which the physicians and hospital could be held liable’. In the Jean Elbaum case, the judge ruled that a nursing home could not collect its fees of over $100 000 for the continued technological feeding of the PVS patient as the feeding was against the wishes of her surrogate.

Having demonstrated that the law does allow artificial nutrition and hydration to be withheld or withdrawn in certain circumstances, the ethical dilemmas of such actions and omissions are now considered. As already mentioned, the initiation of artificial nutrition and hydration in the elderly or the terminally ill is not supported by all physicians, and so is not offered to all eligible patients. The type of treatment patients can expect to receive is, therefore, a lottery depending on the preferences, beliefs and moral convictions of the physician under whose care they find themselves. In order to understand how this dichotomy of beliefs can exist, it is necessary to examine the principles of health care ethics and the main ethical theories which influence medical decision-making.

Ethical theories

In the health care setting where judgements are made which affect other people, a subjective form of ethics, or following one’s conscience based on personally held values and beliefs, is inadequate and would be a weak argument in a court of law. Health care professionals need to be able to understand and employ more formal and objective systems of reasoning if they are to defend their judgments. These formal systems embody ethical theories, moral principles, and also the codes and standards that are set by professional bodies such as the United Kingdom Central Council (UKCC 1992) Code of Professional Conduct.

The two broad ethical theories which influence health care are those of deontology (non consequentialism) and teleology (consequentialism). These two theories disagree on what behaviour or acts should be judged to be right or wrong. Consequentialists maintain that nothing is ethically good or bad in itself, and morality is determined by the consequences of the act, and it will even support the notion that ‘the end justifies the means’. An act is considered ethical if it produces, or is intended to produce, the greatest ratio of happiness over unhappiness (or good over evil) or the best long term consequences when compared with other available options.

This ethic is appropriate providing there are no
conflicting interests, but humanity lives in close proximity and what benefits one person may be at the expense of another. This dilemma has led to three distinct classifications of consequentialism. These are: egoism — the greatest happiness for the person acting; limited consequentialism — for a group, e.g. a group of patients; and utilitarianism — for everyone.

The doctrine of utilitarianism was developed by the British philosopher and judge Jeremy Bentham (1748–1832), who advanced the ethic as a basis for reform. He claimed that one could scientifically ascertain what was morally justifiable by applying the principle of utility. He explained the principle of utility as a means of enhancing the happiness of the community. Bentham’s ideas had great influence on the reforms of the latter part of the 19th century in the administration of government, and on criminal and civil law.

Utilitarian ethics are of particular significance in the provision of health care, when limited available resources have to be apportioned in ways that benefit the greatest number of people. In the United States of America in 1990 it was estimated by the American Medical Association (1990) that between 15,000 and 25,000 patients were being maintained in a persistent vegetative state. The utilitarian view would question the morality of artificially maintaining severely physically and mentally impaired elderly patients into advanced age because of the associated drain on limited resources.

Consequentialists would also argue that when it is difficult, if not impossible, to determine if any benefit is being bestowed on these patients, and the infliction of harm cannot be ruled out, there are no ethical reasons why artificial nutrition and hydration should be continued. However, the fact that withdrawal of this treatment ultimately leads to the consequence of death confounds the reasoning and raises the question, which is more desirable or benefits the patient most — living or dying? In order to attempt to answer this question another dimension needs to be added namely quality of life.

Quality of life

The term ‘quality of life’ is frequently used by health care professionals, but it is a complex concept that lacks a common definition, resulting in inconsistencies in its interpretation. One way of interpreting the concept is to give quality a numerical value and quantify life in number of years, as in Quality Adjusted Life Years or QUALYs. This is a utilitarian ethic that can be utilized by health care providers to decide which treatments or which patients represent the best use of available resources.

However, this is a cold and impersonal ethic that has no place at the bedside. More appropriate is the general consensus that quality of life is multi-dimensional and multi-faceted, and has both subjective and objective components (Meeberg 1993). In practice, it is difficult for us to judge another’s quality of life without allowing our own value systems to override the beliefs, feelings, wants, needs, and aspirations of the other. More significantly, when making decisions for non autonomous people, their subjective component is clearly missing, necessitating onlookers to draw on their own values, thus leaving the quality of life argument seriously flawed.

The second ethical theory, deontology, differs from teleology in the sense that certain acts are seen as intrinsically right or wrong in themselves, regardless of the outcome of the action. This non consequentialist theory is based on the teachings of the German philosopher Immanuel Kant (1724–1804), and is the basis of Christian ethics. According to Gotterbarn (1995), no matter how intelligently one acts, the results of human actions are subject to accident and circumstance, therefore, the morality of an act must not be judged by its consequences, but only by its motivation. The principle governing behaviour in Kantianism is duty. Behaviour is judged to be ethical when acted out of duty, and for this reason deontology is sometimes referred to as duty ethics.

As the ultimate moral principle, Kant states the golden rule, ‘act in such a way that it is possible for one to will that the maxim of one’s action should become a universal law’ (Gotterbarn 1995). This rule is called the ‘categorical imperative’ because it is unqualified and a command. Kant further insists that human beings can never be ethically treated as a means to an end. The non consequentialist view of artificial nutrition would be that the provision of food and water are moral duties, and their non provision or withdrawal would be unethical. Even greater weight is added to this argument when the categorical imperative is applied. This states that if an act is considered moral, then it can become a universal law. So if it is right to withhold sustenance from one person, then it can morally be withheld from everyone, and conversely if it is wrong to withhold it in one instance, then it will be universally wrong.

PRACTICAL APPLICATION

Closely adhering to one or other of the main ethical theories would have serious shortcomings as neither are totally appropriate nor workable in the health care setting. However, the application of a combination of the best elements of consequentialism and non consequentialism, namely, ‘do your duty’, ‘do no harm’, and ‘strive always to obtain the best possible results’, is more appropriate and lays a more workable foundation for health care ethics. Two of these principles are reflected in the four fundamental principles of health care ethics which, according to Gillon (1986) and Beauchamp & Childress (1989), need to be considered when ethical judgments are made.

These are: the ‘principle of respect for autonomy’, the ‘principle of nonmaleficence’, the ‘principle of
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beneficence’, and the ‘principle of justice’. This means that when making ethical judgments, health care professionals need to have respect for the person’s autonomy, cause him no harm, if possible engender benefit, and consider fairly the interests of all those affected. A fifth principle may also be added, namely, ‘respect for the person’, which envelops the notion of personhood and has at its root the desire to avoid suffering.

Making ethical decisions which are objective rather than conscience-led is difficult, but professionally desirable. Attempting to decide and act morally by working within the boundaries and guidelines of ethical theories, principles, codes and standards is not an easy task, especially when theory, code and duty conflict. It is inevitable that, when faced with the dilemma described, different doctors will decide on different solutions. The fact that it is mainly the medical profession that makes the decisions when ethical dilemmas arise, raises another issue. The medical care of the patient is the responsibility of the physician, and the nurse is under a certain obligation to accept and carry out the reasonable orders of the doctor. However, nurses' responsibilities do not end here, as they also have responsibility for the patient’s well-being and are accountable for their actions, even when carrying out doctors’ orders. Not only do nurses have the right to question orders, they could be held professionally and legally accountable for not questioning an order which compromised the health or well-being of a patient. The phenomenon which allows a person to accept and carry out a judgment made by another is called ‘second order reasoning’. This concept was described by Joseph Raz (1975), and Thomas May (1993) applied the concept to the nurse–physician relationship.

May (1993) explains that the basis for nursing’s obligation to carry out the physician’s orders lies in the credentials of the physician. This is rational and desirable when the orders are based on medical reasoning, but the dilemma in question requires an ethical rather than purely medical reasoning, and there is no evidence that doctors are more qualified in ethical reasoning than nurses, and so should not be allowed the monopoly on ethical decision-making.

**Differing ethical standpoints**

The view that the nursing and medical professions have differing ethical standpoints is well supported in literature (Tschudin 1992, Tingle & Cribb 1995). There is a possibility that this phenomenon exists because of the differing male and female morality, the male logic dominating medicine, and the female, nursing. The masculine morality emphasizes rules and reduces morality to a set of principles that can be logically analysed (reduction). This fits well with Kantian concepts which tend to be impersonal and detached from feeling. Nursing ethics, on the other hand, are prescriptive and based on relationships rather than rules, involvement instead of detachment. If nurses were to play a more active role in ethical decision-making a balance of the two ethical perspectives might be achieved. Not only might it be desirable for nurses to become more involved in ethical reasoning concerning their patients, they have a professional obligation to so, or else they neglect the role of patient advocacy.

**CONCLUSION**

Some of the difficulties encountered when making decisions which affect non autonomous persons have been discussed, as have possible solutions in the form of surrogacy and advance directives. The legal profession has also demonstrated that it respects clinical judgment when consideration is given to the benefit over burden analysis. Furthermore, the courts make no legal distinction between acts or omissions (withdrawing or withholding treatment). So the original question ‘can artificial nutrition and hydration be legally or ethically withheld or withdrawn?’ has been answered in part — it is within the law in certain definable circumstances.

However, the legal profession has limited knowledge of medical matters and relies heavily on the medical profession itself for guidance. A bias towards the reductionist ethos may therefore be developing. The developing case law has at least offered reassurance to nurses that it considers artificial nutrition and hydration to be a treatment that is distinct from nursing care. Nonetheless, acting within the law is not necessarily synonymous with acting morally, and after the tube is withdrawn it is nurses who are left to care for the patient until death ensues.

It is interesting to note that although the nurses involved in the Bland case approved of the withdrawal of nourishment, they were not supported by the main nursing association the Royal College of Nursing (Day 1994), who subsequently felt it should remind nurses of their responsibilities, stating that ‘stopping a patient’s food and water was unethical’. The question of whether artificial nutrition and hydration can be ethically withheld or withdrawn has been shown to be much more complex, and it is unlikely that there will ever be a definitive answer. The principle of respect for patient autonomy is paramount in ethical decision-making. Consequently, deciding which course of action to take for non autonomous patients in the absence of a reliable surrogate or advance declaration, be it written or verbal, represents an ethical dilemma of enormous magnitude when the result of the action or omission is the patient’s death. The burden over benefit analysis was shown to be difficult to apply unless death could be deemed to be preferable to life.

Applying the quality of life concept to the problem was found to be of limited value in determining whether death
could be a benefit in these circumstances. Indeed, the concept is dangerously flawed when applied to non autonomous patients as it leaves only the subjectivity of the onlooker and the broad generalizations made by society to guide the quality of life judgment.

When considering the remaining principles that govern health care ethics, it is possible that giving weight to one principle over another, especially when conflicting theories exist, causes the dichotomy of beliefs and the resulting disparities in the way patients are treated, or not treated. It is conceivable that many elderly care nurses are working alongside physicians who either advocate or oppose the treatment per se, without due regard to the individual circumstances of each potential recipient of treatment.

The fact that doctors dominate the ethical decision-making process, resulting in an imbalance which allows the masculine ethic to predominate, has been suggested. This imbalance could be redressed by nurses, but would require them to find the courage to take a more active role in ethical decision-making.

References

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