Can you provide some guidance about oral nutrition at the end of life?

When weighing end-of-life interventions in progressive life-limiting illness, it is usually helpful to consider the hoped-for goals and whether the intervention is expected to achieve them. With feeding, there are various goals people might seek, such as:

- Preventing hunger.
- Preventing malnutrition—Malnutrition is a physiological term and does not mean that hunger is also present. In advanced life-limiting illnesses (such as cancer and dementia), as death nears, there is compromised nutrition, but rarely is there significant or persistent hunger.
- Preventing "starving to death"—This is different from malnutrition. "Starvation" evokes images of hunger and suffering, of being deprived of food although desiring it. It is an emotionally laden term, and is strongly tied to a person's experience of the situation. In contrast, malnutrition is a more clinical term describing the physiological state described above.
- Increasing strength, energy and functional status.
- Living longer.
- Demonstrating a continued professional or personal commitment to the patient by nurturing, not abandoning, him or her.
- Maintaining a consistent moral or religious framework that promotes feeding and hydration until death occurs.

It is important to recognize that within the health care team, as well as within families, different people may hold different goals for feeding at the end of life. This can lead to conflict, which will be particularly difficult to resolve unless people understand each other's goals rather than assume what they are. Open dialogue is required to understand why people take particular approaches to nutrition at the end of life. Common ground for all is to ensure that the patient is comfortable and treated with dignity and respect. Acknowledge this when working through conflict.

By using our knowledge of nutrition and the natural process of dying, we can address some of the above goals:

- Hunger is usually absent as death nears, so feeding to prevent hunger is not usually indicated unless the patient desires food. Provide small amounts of favourite foods, if the patient requests it and swallowing is safe. Often just a mouthful or a sip is enough. If swallowing is not safe, thicken the food and fluid. However, a patient may decide to swallow normal food and fluids and accept the risk of aspiration.

  If there is no hunger or desire for food, then forcing intake might risk making the patient nauseated or bloated. If hunger is not present, we believe that the word "starvation" does not apply, as the implied distress is absent.

- Nutrition is almost always compromised in the final phase of progressive terminal illness. However, providing calories cannot change that because the body is not able to use them for energy or to build muscle, fat and so on. Even if small amounts of high-calorie supplements are provided, they won't make a difference. In the final phase of a terminal illness, a catabolic state develops in which the body's own muscle, carbohydrates and fat are used for energy, regardless of food intake. Providing calories at this time does not result in weight gain, improvement in strength, energy or functional status, and offers no survival benefit.

  Since several of the above goals cannot be achieved through feeding, the most important approach is to "feed for comfort." Provide small amounts of favourite foods, but only if desired by the patient.

- When people feel compelled to feed a patient in order to demonstrate nurturing or their continued professional or personal commitment, it is important to help them find other ways to provide care. For example, family members may be able to help with the patient's mouth care.
- When moral or religious beliefs affect caregivers' approach to food and fluids at the end of life, look for an opportunity for respectful, safe dialogue. Leaders in the faith community may need to provide guidance, particularly if family members or professionals are uncertain about their religion's teachings on end-of-life care. Health care professionals may need to transfer care to a colleague if they feel morally vulnerable.

Thus, the recommended approach to feeding at the end of life is to "feed for comfort." Provide small amounts of favourite foods, if requested by the patient, and only basic mouth care if no intake is desired. High-calorie supplements do not provide more than water or juice, and will not prolong a patient's life because the body does not use these calories.

References

Acreman S. Nutrition in palliative care. Br J Community Nurs. 2009;14(10):427-431.

Palecek EJ, Teno JM, Casarett DJ, et al. Comfort feeding only: a proposal to bring clarity to decision-making regarding difficulty with eating for persons with advanced dementia. J Am Geriatr Soc. 2010;58:580-584.