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RESEARCH

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KEEP OR SUSPEND FOOD IN THE END OF LIFE PHASE? SCOPING REVIEW

*Manter ou suspender a alimentação em fase final de vida? Scoping Review**¿Mantener o suspender los alimentos en la fase del fin de la vida? Scoping Review***Betânia Huppel**¹ **Francine Casarin**² **Liliane Alves Pereira**³ **Rosana Huppel Engel**⁴ **Oclaris Lopes Munhoz**⁵ **Silomar Ilha**⁶ 

ABSTRACT

Objective: To map the production of knowledge about the maintenance or suspension of food in patients in the final stage of life. **Method:** Scope review carried out in five databases. Observational and experimental studies were included. Recommendations from the Jonna Briggs Institute (JBI) and the Preferred Reporting Items for Systematic Review and Meta-Analyses-Scoping Review followed. Descriptive and narrative analysis and synthesis. **Results:** Twelve articles were included, published between 1987 and 2021. As main criteria for suspension life: expectancy of less than 4 months; patients with advanced dementia; severe functional deficit. For maintenance/implementation of artificial feeding, the following should be considered: exhausting all possibilities of natural feeding and uncertain prognoses; opt for proper positioning of the patient and offer small amounts of food orally. **Conclusion:** The production of knowledge related to the suspension or maintenance of enteral feeding is limited. In addition to the above, the desire, beliefs, culture and decision of the patient and/or responsible family members must be considered.

DESCRIPTORS: Adult; Elderly; Diet; Palliative care.

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RESUMO

Objetivo: Mapear a produção do conhecimento acerca da manutenção ou suspensão da alimentação em pacientes em fase final de vida. **Método:** Revisão de escopo realizada em cinco bases de dados. Foram incluídos estudos observacionais e experimentais. Seguiram-se recomendações do Instituto Jonna Briggs (JBI) e do *Preferred Reporting Items for Systematic Review and Meta-Analyses-Scoping Review*. Análise e síntese descritiva e narrativa. **Resultados:** Foram incluídos 12 artigos, publicados entre 1987 e 2021. Como principais critérios de suspensão: expectativa de vida inferior a 4 meses; pacientes com demência avançada; déficit funcional grave. Para manutenção/implementação da alimentação artificial sugere-se considerar: esgotar as possibilidades de alimentação natural e prognósticos incertos; optar pelo posicionamento adequado do paciente e a oferta de pequenas quantidades de alimento via oral. **Conclusão:** A produção do conhecimento relacionada a suspensão ou manutenção da alimentação enteral é limitada. Além do supra escrito, deve-se considerar o desejo, crenças, cultura e decisão do paciente e/ou familiares responsáveis.

DESCRITORES: Adulto; Idoso; Dieta; Cuidados paliativos.

RESUMEN

Objetivos: Mapear la producción de conocimiento sobre el mantenimiento o suspensión de alimentos en pacientes en etapa final de vida. **Método:** Scoping review realizada en cinco bases de datos. Se incluyeron estudios observacionales y experimentales. Siguió las recomendaciones del Instituto Jonna Briggs (JBI) y del *Preferred Reporting Items for Systematic Review and Meta-Analyses-Scoping Review*. Análisis y síntesis descriptiva y narrativa. **Resultados:** Se incluyeron 12 artículos, publicados entre 1987 y 2021. Como criterio principal de suspensión: expectativa de vida menor a 4 meses; pacientes con demencia avanzada; Déficit funcional severo. Para el mantenimiento/implementación de la alimentación artificial se debe considerar: agotar todas las posibilidades de alimentación natural y pronósticos inciertos; optar por el posicionamiento adecuado del paciente y ofrecer pequeñas cantidades de comida por vía oral. **Conclusión:** La producción de conocimiento relacionado con la suspensión o mantenimiento de la alimentación enteral es limitada. Además de lo anterior, se debe considerar el deseo, creencias, cultura y decisión del paciente y/o familiares responsables.

DESCRIPTORES: Adulto; Anciano; Dieta; Cuidados paliativos.

INTRODUCTION

Food is an essential factor in humanity's routine and a basic need. Since the dawn of life, human beings have always sought food and have come to see it as a moment of pleasure, fraternization and friendship, becoming a cultural moment.¹

Despite all the benefits of food, with the progression of some limiting diseases, such as dementia and cancer, people develop difficulty swallowing/digesting/absorbing food and lose their sense of taste, which can cause low self-esteem and even social isolation. This condition, combined with the other situations experienced during this period, predisposes to depression.²

It is well known that there are health conditions that cannot be cured, which leads to the need for palliative care (PC). The purpose of PC is to promote quality of life (QoL) and relieve bio-psycho-spiritual suffering.³ It should be noted that this method of care does not only apply to people who are seriously ill, but to all people living with life-threatening illnesses that cannot be cured.⁴

In these situations, PCs are used to provide care that goes beyond curing, relieving pain and unpleasant symptoms, offering support so that the patient has autonomy, where possible, until death. In this way, family members are also offered support as they cope with the disease and mourn, ensuring a multi-professional approach, focusing on the needs of the patient and family members.⁵

As the disease progresses, PC becomes increasingly essential and, at this stage of life, care is aimed at promoting comfort, re-

lieving pain and suffering, issues considered fundamental in the process of a good death. To this end, procedures that artificially support organs and vital signs with the aim of prolonging life should be avoided, without considering the patient's comfort and dignity.⁶

When it comes to making the decision to maintain or suspend feeding in the final phase of life, there is an ethical issue that is difficult to discuss. There is no consensus, nor are there any criteria for deciding about feeding in the final phase of life⁷ (the last hours or weeks of life, associated with advanced functional and physiological decline, and which depends on the uniqueness of each patient).^{4,6-7} In this context, on the one hand, there are the relatives, who feel that they are "letting the patient starve to death"; on the other hand, there are the professionals, sometimes with limited information/knowledge on the subject and lack of time in the face of emergencies, promoting disproportionate or futile practices, which can result in pain or discomfort for the patient.⁸

Therefore, there is a need to look for evidence on the subject that can help support the decision-making of the interprofessional team. With a scientific basis, for example, a manual of standard operating procedures can be drawn up to guide care and decision-making together with patients/family members, which will enhance dignified, ethical care that promotes the QoL of patients at the end of life.

The aim of this study was to map the production of knowledge about the maintenance or suspension of feeding in end-of-life patients.

METHODS

Type of study

This is a scoping review (SR), a type of study that aims to map the main concepts that underpin a particular area of knowledge, clarify areas of research and identify gaps in knowledge.⁹ The recommendations of the Jonna Briggs Institute (JBI)⁹ and, for clarity and transparency in writing, the Preferred Reporting Items for Systematic Review and Meta-Analyses-Scoping Review (PRISMA-ScR) checklist, were followed.¹⁰

To conduct the review, the following phases were followed: identification of the guiding question; identification of relevant studies; selection of studies; mapping of knowledge production; grouping, summarizing and reporting the results.¹¹

The mnemonic strategy PCC (Population, Concept and Context) was used to construct the SR research question.⁹ The following definitions were made: P - adult and elderly patients in the end-of-life process; C - feeding; C - maintenance or suspension of feeding in the end-of-life process. Based on these definitions, the following review question was established: "What are the criteria for maintaining or suspending feeding in adult and elderly patients at the end of life?".

Study selection criteria

We included observational or experimental studies that addressed criteria for maintaining or discontinuing feeding in adult and elderly patients at the end of life, in Portuguese, English and/or Spanish. Methodological studies were excluded. No time frame was applied and duplicate studies were considered only once.

Sampling and definition of primary study sources

The bibliographic survey was carried out in the following databases: Medical Literature and Retrieval System Online (MEDLINE), via PubMed; Latin American and Caribbean Health Sciences Literature (LILACS) and Nursing Database (BDENF), via the Virtual Health Library (VHL); Scopus (Elsevier) and Embase (Elsevier).

Information source search strategies

The search strategies for each data source were applied on October 7, 2022. Controlled terms were searched using Health Sciences Descriptors (DeCS) and Medical Subject Headings (MESH), taking into account the particularities of each source; uncontrolled terms were also used. The strategies were combined with Boolean "AND" and "OR" operators. A detailed description of the search strategy is shown in Chart 1.

The online software Rayyan - Intelligent Systematic Review was used to manage the references. To minimize possible biases, the selection of materials was carried out in a double independent manner. Initially, the words contained in the titles, abstracts and descriptors were analyzed. Afterwards, the included studies were read in full, taking into account the selection criteria. Next, the data field was compared, checking for possible discrepancies and reaching a consensus between the parties. Disagreements were resolved with the help of a third reviewer.

Table 1 - Information source strategies for the scoping review

DATABASES	SEARCH STRATEGIES
LILACS & BDENF Via BVS	adulto OR idoso OR "pessoa idosa" OR adult OR aged AND dieta OR alimentação OR "regime alimentar" OR "terapia nutricional" OR "ciências da nutrição" OR nutrição OR diet OR diets OR "nutrition therapy" OR "nutritional sciences" OR nutrition AND "cuidados paliativos" OR "cuidados paliativos na terminalidade da vida" OR "palliative care" OR "care palliative" OR "hospice care" OR "program hospice" OR "bereavement Care"
MEDLINE via PubMed	(adult OR aged) AND (diet OR "nutrition therapy" OR "nutritional sciences" OR nutrition) AND ("palliative care" OR "care palliative" OR "hospice care" OR "program hospice" OR "bereavement Care")
EMBASE (Elsevier)	('adult'/exp OR adult OR 'aged'/exp OR aged) AND ('diet'/exp OR diet) AND ('palliative therapy'/exp OR 'palliative therapy')
SCOPUS (Elsevier)	TITLE-ABS-KEY (adulto OR idoso AND dieta OR "terapia nutricional" OR "ciências nutricionais" OR nutrição AND "cuidados paliativos" OR "programa de cuidados paliativos" OR "cuidados de luto")

Data extraction

The data was extracted using a form drawn up in Excel® software, making it easier to summarize the publication data. The following were considered: title, month and year, authors, country of publication, objective, methodological characteristics, level of evidence and main results. In order to minimize bias, the information included in the evidence synthesis was extracted independently. In this process, each reviewer extracted the information using a form and the data validation tool. There were no disagreements at the consensus meeting. The extracted results were then compiled into tables and discussed descriptively based on conceptual category classifications (Chart 2).

Critical evaluation of the selected studies

The level of evidence of the included studies was assessed. They were classified according to the JBI9 as: Level 1: Experimental research designs; Level 2: Quasi-experimental designs: 2.a) Systematic review of quasi-experimental studies; 2.b) Systematic review of quasi-experiments and other study designs with less evidence; 2.c) Prospectively controlled studies of quasi-experiments; 2. d) Pre-test and post-test or retrospective historical controlled group studies; Level 3: Observational - analytical designs: 3.a) Systematic review of comparable cohort studies; 3.b) Systematic review of comparable

cohorts and other study designs of lesser evidence; 3. c) Cohort study with control group; 3.d) Case-control study; 3.e) Observational studies without a control group; Level 4: Observational - descriptive studies: 4.a) Systematic review of descriptive studies; 4.b) Cross-sectional study; 4.c) Case series; 4. Level 5: Expert opinion - laboratory bench research: 5.a) Systematic review of expert opinion; 5.b) Expert consensus; 5.c) Laboratory bench research/expert opinion. Level 1 being a high level of quality of evidence and level 5 a low level of evidence.⁹

Synthesis of the evidence found

When considering the possibilities of synthesis, using absolute (n) and relative (%) frequencies, the results extracted were compiled into tables and discussed descriptively based on conceptual category classifications.

RESULTS

Based on the search strategies in the databases, it was possible to identify 3313 productions, with 1101 duplicates that were only considered once. Thus, in the title and abstract selection phase, 2212 productions were read. Of these, 2183 were excluded because they did not meet the selection criteria. In the next stage, 29 articles were selected for reading in full, eight of which were not available in full. As a result, the authors were contacted via e-mail (waiting two weeks); six responded and made their articles available, and two did not, and were excluded from the review. Twenty-seven articles were then read in their entirety, and 15 were excluded because they did not present the criteria for suspending or maintaining feeding during the end of life, or because they were presented as hospital leaflets. Finally, 12 (100%) productions remained for evidence synthesis (Figure 1).

The articles selected (n=12; 100%)12-23 were published between 1987 and 2021, with a predominance in 2021 and 2017 (n=04; 33.33%) and in English (n=11; 91.66%). The main diagnoses leading to the end-of-life process were advanced dementia (n=6; 50%) and cancer (n=8; 66.66%), with both pathologies being identified in some articles.

Figure 1 - Flowchart for searching and selecting references, adapted from PRISMA ScR10

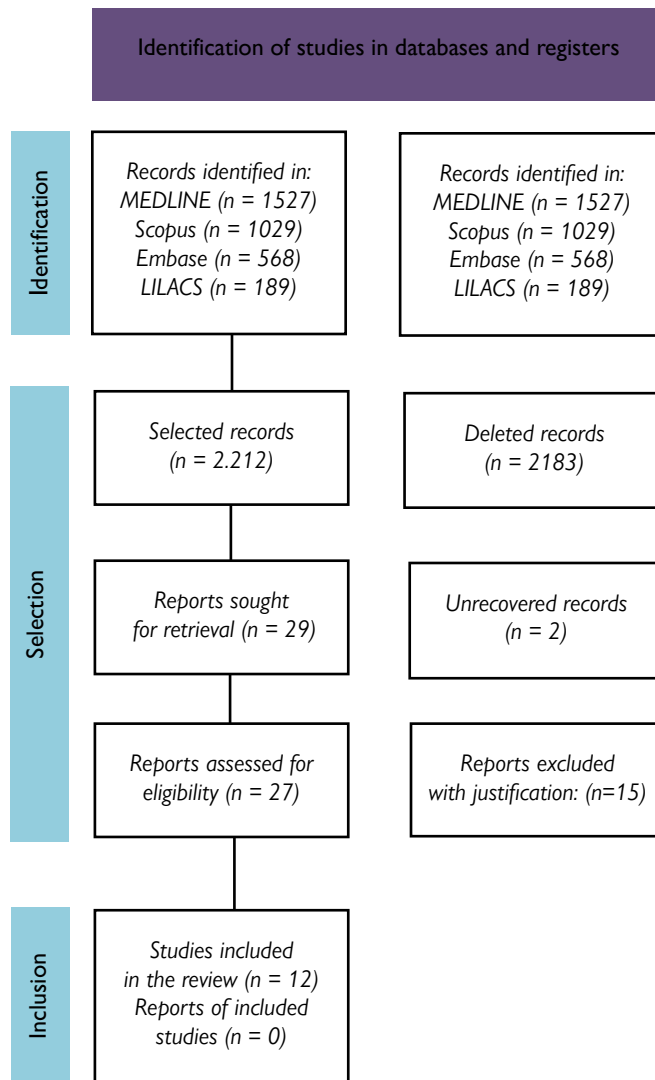


Table 2 below shows the other characteristics of the articles selected.

Chart 2 - Characteristics of the selected studies, in terms of title; objective; language and country of research; type of study and level of evidence; main results and conclusion

Title/ Authors/ Date of publication	Objective	Language/ Country of search	Type of study/ Level of Evidence (LE)	Main results and conclusion
Care of the adult cancer patient at the end of life: ESMO Clinical Practice Guidelines / Crawford1 et al. 202112	Not applicable	English/ Switzerland	ESMO Clinical Guideline/ NE 3	In patients expected to survive less than a few weeks or days, the invasiveness of nutrition and interventions should be reduced and dietary advice and oral supplements should be provided, and comfort should be prioritized.

<p>End-of-Life Nutrition Considerations: Attitudes, Beliefs, and Outcomes / Tyler S. Loofs; Kevin Haubrick; 202113</p>	<p>To evaluate the physiological outcomes and interpersonal influences that should be considered when making the decision to provide artificial nutrition and hydration (AN&H) to patients in palliative care programs.</p>	<p>English/ United States</p>	<p>Systematic review/ NE 4</p>	<p>Enteral nutrition (EN) may have some benefit for improving the duration of survival, specifically in comatose patients (95% CI 0.42-0.66), although it is also associated with decreased survival for patients with other diagnoses, including multiple organ failure with sepsis or acute respiratory failure (95% CI 1.04-1.41), chronic obstructive pulmonary disease (COPD) (95% CI 1.04-1.80) and respecting the belief and culture of the patient and family members when making decisions.</p>
<p>Ethical issues and dilemmas in artificial nutrition and hydration / Cardenas, D; 202014</p>	<p>Identify ethical issues and dilemmas in nutritional therapy, provide rational justification for ethical decisions in the field of nutritional therapy and improve ethical reflection in the field of clinical nutrition.</p>	<p>English/ Colombia</p>	<p>Expert opinion/ NE 5</p>	<p>In the last few weeks of life, artificial nutrition has little or no benefit, as it will not result in any functional or comfort benefits for the patient. Starvation is rare in patients with imminent death and minimal amounts of desired food can provide adequate comfort. It is important to recognize that even small amounts of food can be meaningful to the patient and contribute to a sense of well-being. Therefore, manual oral feeding should be chosen, always respecting the patient's autonomy and dignity.</p>
<p>Artificial Nutrition and Hydration in People With Late-Stage Dementia / Smith; Ferguson; 201715</p>	<p>To examine the evidence on the use of artificial nutrition and hydration for patients with end-stage dementia and offer implications for home care clinicians.</p>	<p>English/ Huntsville United States</p>	<p>Case study/NE 4</p>	<p>Position statements on artificial nutrition near the end of life by the American Association of Hospice and Palliative Medicine and the Hospice and Palliative Nurses Association state that artificial nutrition and hydration do not prolong life and may actually increase burden and mortality in some populations. Artificial nutrition through tube feeding can create a substantial burden due to frequent transfers to emergency departments for complications arising from the tube, such as dislodgement, withdrawal or obstruction. In addition, rather than healing pressure ulcers, tube feeding is associated with the development of new pressure ulcers, as well as tube-related infections, recurrent aspiration, diarrhea, restraint use and discomfort.</p>

<p>Withdrawing or withholding life-sustaining clinically-assisted nutrition and hydration / Richard Griffith; 201716</p>	<p>Consider the rights and responsibilities of the district nurse when assessing the withdrawal or discontinuation of clinically assisted nutrition and hydration.</p>	<p>English / United Kingdom</p>	<p>Literature review / NE 5</p>	<p>The courts have long recognized that maintaining artificial nutrition for very ill or seriously ill patients can be futile. Futile treatments can be legally withheld or withdrawn. A case can still be referred to the Court when there is disagreement about the best interests of the person or the legality of withdrawing artificial nutrition. Both the Court of Protection and the Supreme Court now hold that the withdrawal of artificial nutrition must be in the best interests of the patient and/or responsible family members.</p>
<p>ESPEN guideline on ethical aspects of artificial nutrition and hydration / Druml et al, 201617</p>	<p>This guideline provides a critical summary for caregivers regarding the ethics of artificial nutrition and hydration therapy. The guideline is adult-oriented; ethical aspects may differ in children and adolescents.</p>	<p>English / Austria, Germany, Israel, Netherlands, Switzerland and United Kingdom.</p>	<p>Clinical guidelines/ NE 4</p>	<p>The decision to discontinue artificial feeding can be misinterpreted as a "do not feed" order, as nutrition is associated with life and its absence with hunger. For patients with feeding difficulties who need support, an individualized care plan should be established. Such a feeding care plan should be called "comfort feeding" to avoid the negative connotation of the statement.</p>
<p>Ethical Issues in Artificial Nutrition and Hydration: A Review / Geppert et al. 201018</p>	<p>The aim of this review is to provide Artificial Nutrition and Hydration (ANH) professionals with a framework of clinical evidence, ethical principles, legal precedents and professional guidelines to improve their knowledge and decision-making skills about ANH.</p>	<p>Spanish / Mexico</p>	<p>Literature review / NE 5</p>	<p>Gastrostomy can reduce the risk of aspiration, but may not reduce the risk of pneumonia. Feeding lower in the gastrointestinal tract may decrease reflux, regurgitation and aspiration, but the risk of pneumonia may remain unchanged. For patients at high risk of pressure ulcers, gastrostomy feeding will not prevent the development of pressure ulcers or aid healing. Gastrostomy may not result in a better quality of life for patients with advanced dementia, but it may result in a better quality of life for family members and caregivers who are concerned about the patient's diet.</p>
<p>Artificial Nutrition and Hydration for the Terminally Ill A Reasoned Approach / Suter et al. 200819</p>	<p>This article provides a review of the evidence related to artificial nutrition and discussion about patients and families in palliative care.</p>	<p>English / United States</p>	<p>Literature review/ NE 4</p>	<p>Research shows that 63% of patients don't feel hungry at the end of their illness and 34% only feel hungry at the beginning. Hunger symptoms can be relieved with small amounts of food and water or pieces of ice. Researchers have compared the use of tube and oral feeding at the end of life and have not obtained convincing results on the use of the tube. They did not show that the use of a tube reduced the risk of aspiration pneumonia or other benefits and comfort of survival. They also state the other risks that probing can cause, discouraging the practice.</p>

<p>Summary version of the Standards, Options and Recommendations for palliative or terminal nutrition in adults with progressive cancer / Bachmann et al. 200320</p>	<p>The aim is to define recommendations for nutritional management in adult patients with progressive terminal cancer.</p>	<p>English/France</p>	<p>Expert opinion / NE 4</p>	<p>Routine palliative artificial nutrition is not justified in terminally ill patients, as they often do not feel hungry or thirsty, and the benefits have not been demonstrated. Artificial nutrition should not be started if the patient's life expectancy is less than 3 months and/or there is a severe and permanent functional deficit, as assessed by a Karnofsky index of 50% or less.</p>
<p>Nutrition and hydration for terminal cancer patients in Taiwan/ CHIU et al. 200221</p>	<p>To assess the frequency and causes of inability to eat or drink in terminally ill cancer patients and to investigate the use of artificial nutrition and hydration, the frequency, type and the extent to which staff felt that artificial nutrition and hydration could be ethically justified.</p>	<p>English / China</p>	<p>Cross-sectional study/ NE 4</p>	<p>Sensitive care and continuous communication are likely to reduce the use of artificial nutrition in terminally ill cancer patients. The use or not of artificial nutrition did not influence survival in this study. Thus, the goals of care for terminal cancer patients should be reoriented towards promoting quality of life and preparing for death, rather than simply highlighting all efforts to improve hydration and nutritional status.</p>
<p>Comfort Care for Terminally Ill Patients The Appropriate Use of Nutrition and Hydration / MCCANN et al. 199422</p>	<p>To determine the frequency of hunger and thirst symptoms in a group of terminally ill patients and to determine whether these symptoms can be alleviated without forced feeding, forced hydration or parenteral nutrition.</p>	<p>English New York</p>	<p>Case studies/ NE 4</p>	<p>Thirty-two patients were followed up over 12 months, and 20 patients (63%) never felt hungry, while 11 patients (34%) only had symptoms initially. Similarly, 20 patients (62%) felt no thirst or only thirst initially during their terminal illness. In all patients, the symptoms of hunger, thirst and dry mouth could be relieved with small amounts of food, liquids and/or by applying ice chips and lubricating the lips.</p>
<p>The Clinical Case Against Tube Feeding in Palliative Care of the Elderly/ CAMPBELL-TAYLOR e FISHER, 198723</p>	<p>Positioning against tube feeding in a specific subset of elderly, terminally ill patients.</p>	<p>English / Canada</p>	<p>Expert opinion / NE 4</p>	<p>When considering tube feeding for elderly and palliative patients, the final outcome of the intervention should determine the decision to implement it. If the aim of the treatment is to provide safe nutrition, the likelihood is that the risk of aspiration pneumonia with tube feeding is as great as with careful spoon feeding. In fact, the risk may be even greater. When such a patient is spoon-fed in an appropriate position (i.e. 60° upright), food and liquid must necessarily be administered in small quantities.</p>

Chart 3 - Criteria for suspending or maintaining feeding in the final phase of life and justification

Criteria for stopping or maintaining feeding in the final phase of life		
Suspension	Maintenance	Justification
<ul style="list-style-type: none"> • Artificial feeding should not be started if life expectancy is less than 3 or 4 months.^{12,16,20} • Tube feeding in advanced dementia or terminally ill patients is not beneficial.^{14,18-20} • Artificial feeding should not be started if there is any severe and permanent functional deficit (Karnofsky index of 50% or less).²⁰ 	<ul style="list-style-type: none"> • Artificial nutrition should only be administered after all possibilities of natural feeding have been exhausted and when the prognosis is uncertain.¹⁶ • At the end of life (last days/months), appropriate positioning should be chosen and small amounts of food should be offered orally and/or ice chips and the lips should be moisturized if the patient reports thirst.^{14,19,22-23} 	<ul style="list-style-type: none"> • Artificial nutrition has little or no functional or comfort benefit for the patient in the last weeks of life. Starvation is rare in patients with imminent death.^{14,19-20,22} • Artificial nutrition and hydration do not prolong life and can increase burden and mortality in some populations.¹⁵ • Futile treatments can be legally withheld or withdrawn.¹⁶
<p>The wishes, beliefs, culture and decision of the patient and/or responsible family members must always be taken into account.^{14,17-19,22}</p>		

In relation to the results of the selected studies, a number of criteria were identified for consideration. For clarity, Table 3 specifies the criteria for suspending or maintaining feeding in the final phase of life, as well as the justification for them.

DISCUSSION

Food is a complex ethical issue, as it has psychological and physiological functions that are considered fundamental in care. In this way, it plays a fundamental role in culture, religious, personal and social values, and is considered essential in maintaining life, no matter how painful its maintenance may be at the end of life, generating therapeutic futility.²⁴⁻²⁵

Oral feeding

The oral route should be chosen as the preferred way of feeding patients in PCs. However, in the final phase of life, most patients lose their appetite, they don't absorb nutrients and they no longer enjoy food, i.e. they don't feel hungry or thirsty.³⁵ They may also feel satisfied with small amounts of food or even with humidification of the oral cavity. Therefore, with the correct positioning (vertical position, at 60°), small amounts of food should be offered with the use of a spoon and ice chips for hydration.^{14,19,22-23}

These interventions have fundamental significance for family members, as they experience the symbolic process that feeding represents. Many family members have the idea that if the patient doesn't eat, they won't be able to live, which has repercussions on feelings of guilt if food isn't offered or administered. This situation sometimes leads family members into a bioethical

conflict, where they want the best for the patient, but are unsure of how to make the best decision.²⁶

In addition, health professionals should welcome and humanize the relationship between professionals and patient/family. To this end, they should look for evidence to promote pain relief and comfort and, through therapeutic communication, allow them to share their anguish.²⁷

Artificial feeding

With the progression of some diseases, PC becomes essential, prioritizing quality of life. In this way, some interventions such as artificial feeding can be considered dysthanasia, i.e. the artificial prolongation of life. In these situations, the central ethical concepts are fundamental: autonomy, beneficence, non-maleficence and justice, which should guide professional interventions, ensuring therapeutic adequacy.²⁸

It is therefore important to decide on the most appropriate time to discontinue treatments that are likely to cause more harm than good to the patient. In this context, orthothanasia emerges, a concept which argues that death should not be anticipated or advanced, maintaining a natural, dignified and peaceful death.²⁹

Artificial feeding was presented in some of the articles found as a therapeutic futility in end-of-life patients with a life expectancy of less than three to four months, also involving patients with advanced dementia and cancer.^{14,19-20}

Similar data was found in a study that aimed to discuss and understand current and global knowledge regarding ethical issues related to food, nutrition and hydration at the end of

life. This study found that artificial nutrition and hydration can cause complications and discomfort for patients, affecting their quality of life and outweighing the benefits, as studies do not prove an increase in survival in patients with advanced disease.³⁰

In these situations, maintaining food is a decision that is considered futile, as the body of a person in the final stages of life has a lower energy requirement and the person has difficulty swallowing, digesting and absorbing food. As a result, the patient may experience regurgitation and reflux and feeding, contrary to what professionals sometimes think, will not prevent pressure injuries.¹³

Although one of the reasons for probing the patient is to prevent aspiration pneumonia, this review showed that artificial feeding does not prevent aspiration.^{12,14-15,18,23} It has benefits in some comatose patients, but does not increase survival in patients with other diagnoses.¹³

In addition, the discomfort caused by restraint to prevent pulling and displacement of the tube has been shown to be an important factor to consider.^{12,15} The final phase of life should be experienced with dignity and comfort with the aim of consoling and relieving, which implies PCs, which consider the subjectivity of each human being. Active listening is also a tool for comforting end-of-life patients and their families, as it seeks to understand their needs and desires in the face of the situation they are experiencing, helping to meet their biopsychosocial and spiritual demands.²⁶

Thus, artificial feeding should only be started after all oral alternatives have been exhausted and the patient's prognosis is still uncertain¹⁵, i.e. in situations where it has not yet been decided whether or not the patient is in the end-of-life process.

Decision by the patient at the end of life and/or their relatives

The decision of the patient and family members was fundamental in all the articles found.¹²⁻²³ Coherent evidence should be promoted, and it should be possible to advise and inform about the benefits and harms of interventions, in order to find a consensus between patients, family members and the healthcare team for decision-making.¹⁷

As already mentioned, family members believe that if they decide to stop artificial feeding, they will be promoting the patient's death, or that providing it orally, in small quantities, is not enough to satisfy the patient nutritionally. It is important to emphasize the need for health professionals to inform family members, clearly and in a language appropriate for their understanding, about human physiology at the end of life, and to reassure them that by deciding to stop feeding, they are not promoting the patient's death.³⁰

It should be emphasized that decision making in matters relating to the final phase of life must be made by the dying person. If this is not possible, it should be decided by their legal representative and/or family members. Both have a fundamental role to play, and must talk to each other and decide which decision will be made, always seeking to respect

the patient's wishes and dignity. In this scenario, healthcare professionals have a responsibility to inform patients and/or family members of evidence regarding comfort measures in the final phase of life.¹⁷

FINAL CONSIDERATIONS

It was possible to find criteria for maintaining or suspending feeding in the final phase of life, however, the literature on the topic is limited. In short, the suspension of artificial feeding is indicated when the patient has just a few weeks to live, and in cases of advanced dementia and/or severe cognitive impairment. On the other hand, artificial nutrition is indicated when the possibilities of natural nutrition have been exhausted and for uncertain prognoses. Furthermore, it is recommended to position the patient appropriately and offer, orally, small amounts of food and/or liquids for hydration. The desire, beliefs, culture and decision of the patient and/or responsible family members must always be considered.

It should be noted that this subject is still fraught with bioethical dilemmas, which need to be addressed by the interprofessional health team and family members. It is therefore hoped that more studies will be carried out and that the gaps in knowledge about the clinical criteria for suspending or maintaining feeding will be filled.

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