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JOSEPHINE G PATERSON

Providing artificial nutrition and hydration in palliative care

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Abstract

This literature review investigates nurses' attitudes towards providing artificial nutrition and hydration (ANH) in the palliative care setting. Various factors that influence nurses' attitudes are examined. While some of the findings have limited generalisability because of the dearth of evidence originating from the UK, United States and western Europe, the issues should still be considered. It is recommended that more research is carried out examining nurses' attitudes towards providing ANH in palliative care in the UK, to gain a better understanding of the factors that may influence decision making.

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Artificial nutrition and hydration, end of life care, nurses' attitudes, palliative care, withholding or withdrawing nutrition.

Review

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PROVIDING PATIENTS WITH food and fluids is an integral part of nursing practice. Maslow (1943) described food and water as two of the most fundamental physiological human needs. Roper *et al* (1996) considered eating and drinking to be an essential act of daily living for which patients may require nursing support. In addition, food and drink has significant psychological, emotional and social meaning for people, and may be associated with nurturing and care (Schmidlin 2008, Holmes 2010).

It is common for patients receiving palliative care to have little or no oral intake. This is usually because patients have reduced levels of consciousness, but may also be the result of anorexia or cachexia, obstruction of the gastrointestinal tract, generalised weakness or loss of appetite (Van der Riet *et al* 2008). If a patient's fluid and nutritional requirements cannot be maintained through oral intake, a decision needs to be made about whether the provision of artificial nutrition and hydration (ANH) is appropriate (Holmes 2010).

ANH is the delivery of fluids and nutrition via an intravenous cannula (parenteral nutrition) or an enteral tube (Arenella 2005). Fluids may also be administered using the subcutaneous route. Use of ANH in patients receiving palliative care is the subject of much debate. Some ethicists feel strongly that withholding ANH in palliative care is unethical because every human has a fundamental need for food and water (Bryon *et al* 2008). It has been suggested that ANH is not a medical treatment that can be withheld or withdrawn near the end of life, but rather it is a component of basic nursing care (Konishi *et al* 2002, Bryon *et al* 2008, Ke *et al* 2008a, 2008b, Miyashita *et al* 2008, Van der Riet *et al* 2008).

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This view is held by many religious figures. In particular, Pope John Paul II (2004) stated that providing food and fluids, regardless of how they are administered, is a natural way of preserving life and as such is a moral obligation.

There are no clear medical indications for providing ANH at the end of life (Danis 2011), although it is often prescribed at this time to prevent dehydration and demonstrate continued support to the patient and relatives (Konishi *et al* 2002, Bryon *et al* 2008, Ke *et al* 2008a, 2008b, Miyashita *et al* 2008, Van der Riet *et al* 2008). However, there is a growing body of evidence suggesting that ANH can be a physiological burden to the dying patient.

It has been argued that ANH can cause side effects such as pain and suffering as a result of the patient being overloaded with fluid, which can cause ascites, and peripheral and pulmonary oedema. The intravenous line that is necessary for administering ANH may also cause pain (Konishi *et al* 2002, Bryon *et al* 2008, Ke *et al* 2008a, 2008b, Miyashita *et al* 2008, Van der Riet *et al* 2008). Those in support of withholding ANH in palliative care argue that patients with mild dehydration die more peacefully and avoid the aforementioned side effects associated with ANH (Konishi *et al* 2002, Ke *et al* 2008a, 2008b).

Regardless of which stance is taken, providing and withholding ANH in palliative care may have many ethical implications for nurses, who may struggle to balance the principles of beneficence, non-maleficence and evidence-based practice (Nursing and Midwifery Council (NMC) 2008). This literature review attempts to explore nurses' attitudes towards providing ANH in palliative care to gain a better understanding of the factors that may influence decision making.

Literature search

To keep the review focused, the author proposed the following research question: 'What are nurses' attitudes towards providing and withholding ANH in palliative care?' A literature search was conducted to find relevant published English language literature using the following databases: AgeInfo, British Nursing Index, Cochrane Library, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Database of Abstracts of Reviews and Effects (DARE), Ovid MEDLINE, Ovid Nursing Full Text and PsychInfo. Online publishers Sage, ScienceDirect and Wiley were also searched.

The search terms used were: withholding fluids; palliative care; denying fluids; withholding hydration; withholding treatment; hydration; end of life; hospice; denying treatment; passive euthanasia; allowing to die; terminal dehydration; terminal hydration; withholding; fluids; denying; fluids; palliative; passive; euthanasia; terminal; dehydration; nurse; attitude; ANH; and perception. Combinations of these terms were entered together using the Boolean operator 'AND'. Within the subject area, articles by Zerwekh (1983) and Wurzbach (1995) were identified as important and so the author's names and article titles were used as search terms for a descendancy search (Polit and Beck 2010). Any article that cited these landmark studies was retrieved.

In addition to the computer search, hard copy editions of relevant journals were hand searched. The search strategy covered the period from January 2000 to April 2011 and 131 articles were retrieved. Inclusion and exclusion criteria (Table 1) allowed selection of six articles that best answered the research question. A summary of the final six reviewed articles is provided in Table 2.

TABLE 1

Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
‣ Original research or systematic literature review of original research. ‣ Providing and withholding artificial nutrition and hydration (ANH) in palliative care. ‣ Nurses' attitude, role, perception and experience. ‣ Nurses' arguments for and against providing and withholding ANH. ‣ Providing and withholding ANH when curative treatment has stopped. ‣ English language. ‣ Published literature. ‣ Published from the year 2000 onwards.	‣ Providing and withholding ANH in dementia care. ‣ Providing and withholding ANH in patients in a persistent vegetative state. ‣ Concerning doctors, patients or relatives' attitudes only. ‣ Opinion articles arguing that ANH provision is right or wrong in palliative care. ‣ Literature reporting statistics on numbers of patients in palliative care receiving ANH or having it withheld. ‣ Focusing solely on the medical ANH decision-making process. ‣ Nurses' attitudes towards switching from curative treatment to palliative care. ‣ Nurses' attitudes towards euthanasia. ‣ Nurses' attitudes towards withholding life-prolonging treatment. ‣ Nurses' attitudes towards end of life care pathways. ‣ Not in English language. ‣ Unpublished studies. ‣ Published before the year 2000.

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Findings

Of the six research articles reviewed, five were primary research studies originating from Japan, Taiwan or Australia. One article described a literature review conducted by a Belgian author who searched for worldwide literature on several electronic databases. No primary research articles were found originating from the UK. While this limits the generalisability of some of the findings, many of the issues highlighted in this literature review warrant consideration and can be used to inform understanding of decisions relating to providing ANH in the UK. The literature search identified five main, and at times overlapping, themes relating to artificial nutrition and hydration. These were: arguments for and against ANH provision, others' influence, ethical factors, clinical factors and legal factors.

Arguments for and against

Nurses' attitudes towards providing ANH varied significantly depending on the scenario (Konishi *et al* 2002, Bryon *et al* 2008, Ke *et al* 2008a, 2008b). Konishi *et al* (2002) surveyed 160 nurses in Japan using a forced-choice questionnaire that asked participants whether they would support withdrawal of ANH from a dying patient in eight different scenarios. In situations where the patient had requested that ANH be withdrawn, or when ANH was causing pain, most nurses agreed that it could be withdrawn. For all other scenarios, most nurses felt that ANH should be provided, including when the patient was near death, unconscious or

TABLE 2

Summary of the six articles selected for review

Article	Sample	Study	Findings
Bryon *et al* (2008)	14 studies	Literature review	▸ Nurses' arguments for and against providing artificial nutrition or hydration can be categorised as ethical-legal, clinical or socio-professional.
Ke *et al* (2008a)	197 nurses	Quantitative: Likert-scale structured questionnaire	▸ Nurses believe the patient's overall condition should influence the provision of artificial nutrition and hydration. ▸ Nurses feel it is their responsibility to inform the patient and relatives about the advantages and disadvantages of artificial nutrition and hydration, while respecting patients' autonomy and psychosocial needs. ▸ A lack of knowledge and misconceptions about artificial nutrition and hydration can affect whether it is provided. ▸ Provision of artificial nutrition and hydration may be influenced by the views of doctors, patients' relatives and other nurses. ▸ Practice may be affected by a fear of dispute or communication issues. ▸ The cultural influence of 'food comes first for people' leads nurses to believe that providing artificial nutrition and hydration is essential care. ▸ Physiological care needs are often addressed above psychological and social needs. ▸ Patient autonomy may be overlooked.
Ke *et al* (2008b)	88 nurses	Quantitative: Likert-scale structured questionnaire	▸ A significant change was noted in nurses' knowledge and attitudes following education. ▸ No significant change was noted in nurses' behavioural intentions following education.
Konishi *et al* (2002)	160 nurses, 5 families	Mixed: questionnaire with forced-choice and open-ended questions	▸ Nurses supported withholding artificial nutrition and hydration only if the patient requested it or it relieved suffering. ▸ Doctors' orders, family requests or patients' advancing age did not ethically justify withholding artificial nutrition and hydration. ▸ Interviews with relatives focused on experiences of their loved ones being given artificial nutrition and hydration. ▸ Influence of ethical, social and cultural factors.
Miyashita *et al* (2008)	3328 nurses, 584 doctors	Quantitative: Likert-scale structured questionnaire	▸ Attitudes towards artificial hydration can vary between doctors and nurses, and in different clinical settings.
Van der Riet *et al* (2008)	15 nurses, 4 doctors	Qualitative: focus group and individual interviews	▸ Carers experience distress when not able to provide medically-assisted nutrition and hydration. ▸ Palliative care doctors and nurses believe that terminal dehydration reduces suffering. ▸ Differences in practice exist between acute and palliative care settings.

very old. Less than one third of nurses felt that ANH should be withdrawn because of requests by doctors or the patient's family.

Ke *et al* (2008a) investigated nurses' intentions to provide ANH to a patient with terminal stomach cancer. The 197 nurses included in the study were selected from the gastroenterology, general surgery and intensive care units of a Taiwanese general hospital. Using a Likert-scale structured questionnaire, 193 nurses reported that they were likely (120 nurses) or very likely (73 nurses) to provide artificial nutrition. Responses showed that 193 nurses were likely (102 nurses) or very likely (91 nurses) to provide artificial hydration in this scenario.

In a follow-up study, Ke *et al* (2008b) investigated whether nurses' attitudes changed following an educational intervention. A similar Likert-scale structured questionnaire was given to nurses in the same workplaces as in Ke *et al*'s (2008a) study, questioning participants on their knowledge of and attitude towards ANH, and whether they would provide or withhold it for a given patient. Half of the nurses in the study (44 of 88) took part in a 50-minute educational lecture. Two weeks later, all of the nurses (n=88) completed the questionnaire again. Ke *et al* (2008b) found that while education improved nurses' knowledge of and attitude towards providing ANH, their intentions did not change significantly. All participants stated that they would provide artificial hydration, and 87 nurses said they would provide artificial nutrition. Despite knowledge and understanding of the disadvantages of providing ANH, such as the risk of infection from intravenous lines, fluid overload, pleural effusion, pulmonary oedema and ascites, almost all nurses opted for its provision.

Bryon *et al* (2008) reviewed the literature to explore whether nurses are mostly for or against providing ANH. Seven electronic databases were searched for relevant articles published between January 1990 and January 2007. The literature identified that figures for those in favour of providing ANH in palliative care ranged from 5-71%; figures for those against providing ANH ranged from 20-95%. This illustrates that nurses' attitudes can vary substantially between studies.

Miyashita *et al* (2008) investigated the adequacy of decision-making discussion among nurses and physicians in relation to ANH, and how nurses' attitudes vary in different settings. A total of 4,210 questionnaires were distributed to nurses in cancer centres, general hospitals and palliative care units in Japan, and 3,328 responses were analysed. Although the study did not provide conclusive information about whether most nurses were for or against providing ANH, it did discuss the socio-professional influences on nurses' decision making in relation to ANH. These findings are discussed later.

Van der Riet *et al* (2008) examined palliative care professionals' perception of ANH by interviewing 15 nurses and four doctors in palliative care units in Australia. Focus group and individual interviews were used for the nurses and doctors respectively, and data were analysed using discourse analysis. The study used a qualitative design to explore nurses' attitudes towards ANH, and these findings are discussed later. Again, the study did not confirm whether most nurses were for or against providing ANH in palliative care.

While Konishi *et al*'s (2002) and Ke *et al*'s (2008a, 2008b) findings imply that nurses mostly agree with providing ANH, this finding may not be generalisable because attitudes towards ANH were limited by specific scenarios. Arguably, the only conclusion to be drawn is that nurses' attitudes towards providing ANH in palliative care vary significantly depending on the particular situation and the complex interplay between socio-professional, ethical, clinical and legal factors (Konishi *et al* 2002, Bryon *et al* 2008, Ke *et al* 2008a, 2008b, Miyashita *et al* 2008, Van der Riet *et al* 2008).

Others' influence

Findings from the literature review suggest that nurses' attitudes towards providing and withholding ANH in palliative care may be influenced by other people – the patient, the patient's family, doctors or other nurses (Konishi *et al* 2002, Bryon *et al* 2008, Ke *et al* 2008a, 2008b, Miyashita *et al* 2008, Van der Riet *et al* 2008). Most commonly, the patient was found to influence nurses' attitudes, and nurses in all six studies in the literature review stated that patient autonomy should be respected when making decisions about ANH. This high regard for patient autonomy echoes the principles in *The Code* (NMC 2008), which is designed to promote good nursing practice and safeguard patients in the UK.

The family's influence on decisions relating to ANH was also mentioned in all six studies, with four studies reporting that families are generally in favour of ANH (Konishi *et al* 2002, Ke *et al* 2008a, 2008b, Van der Riet *et al* 2008). Nurses were also aware of the significance of ANH to family members. Its provision was perceived as a symbol of compassion, nurturing and hope, while withholding ANH was thought to contribute to feelings of fear and abandonment,

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and loss of trust (Konishi *et al* 2002, Van der Riet *et al* 2008).

Difficult situations relating to providing ANH were found to cause conflict and distress (Ke *et al* 2008a, Miyashita *et al* 2008). In Miyashita *et al*'s (2008) study, nurses reported feeling upset when the patient refused artificial hydration, especially when the refusal conflicted with the family's wishes. Konishi *et al* (2002) and Ke *et al* (2008a, 2008b) suggested that patient autonomy was often overlooked in favour of the family's wishes.

A common cause of distress involved the patient's family requesting ANH when its provision was deemed medically inappropriate (Ke *et al* 2008a, Miyashita *et al* 2008). While some nurses expressed a willingness to provide ANH as a gesture of support to the family (Ke *et al* 2008a), others did not consider that patients' relatives should be involved in the decision-making process, and would not justify providing ANH based on their wishes alone (Konishi *et al* 2002, Bryon *et al* 2008). Nurses described using their communication skills when talking to the patient's family as a way of solving any disagreements (Van der Riet *et al* 2008).

Conflicting evidence was found when analysing doctors' influence on nurses' attitudes towards providing ANH in palliative care. In Ke *et al*'s (2008a) study, nurses viewed doctors as the primary decision makers with regard to ANH, and felt a duty to follow medical decisions, even against their own beliefs. In addition, Bryon *et al* (2008) reported that nurses sometimes change their attitude towards ANH based on doctors' orders. However, Miyashita *et al* (2008) found that nurses believed that a doctor alone does not have the power to make a decision about withdrawal of ANH. This finding may have been affected by the way the study question was posed. Miyashita *et al*'s (2008) question of what action nurses felt could be ethically justified is different to Ke *et al*'s (2008a) question of what action nurses were likely to carry out.

The views of other colleagues were found to influence nurses' attitudes towards providing ANH in palliative care. Nurses felt that the opinions of their colleagues were important (Ke *et al* 2008a, Bryon *et al* 2008), and that they might even change their attitudes towards ANH because of the expectations of their colleagues (Bryon *et al* 2008). Alluding to this, Bryon *et al* (2008) described nurses' attitudes as conformist.

Bryon *et al* (2008) and Van der Riet *et al* (2008) recommended a team approach to decision making about providing ANH, yet this is not without problems. Three of the studies found that within the multidisciplinary team, conflicting opinions exist between doctors and nurses, often arising from their respective cure versus care approaches (Bryon *et al* 2008, Ke *et al* 2008a, Van der Riet *et al* 2008).

Ethical factors

Nurses' attitudes towards ANH in palliative care were mainly based on beliefs that mirrored the ongoing ethical debate surrounding providing and withholding ANH in this setting. The most frequently mentioned of these beliefs was that ANH should be given in palliative care because it is more than a medical treatment; it is a component of fundamental nursing care (Konishi *et al* 2002, Bryon *et al* 2008, Ke *et al* 2008a, 2008b, Miyashita *et al* 2008, Van der Riet *et al* 2008). It should be noted that although this is a professional belief it is often used in ethical arguments for providing palliative care. ANH was also thought to be closely linked to compassion and nurturing (Bryon *et al* 2008, Van der Riet *et al* 2008).

Whether ANH is a medical treatment or a component of fundamental nursing care has longbeen debated. One notable case was that of Tony Bland, a patient left in a persistent vegetative state following injury in the Hillsborough football stadium disaster of 1989 in Sheffield, England. In 1993, his family requested that his feeding tube be removed. The case was taken to court and permission to remove the tube was granted. This was considered a landmark trial because during the deliberations, ANH was categorised as a medical treatment that could be withdrawn and not as a component of fundamental nursing care (Wainwright and Gallagher 2007). Although the majority of ethicists view ANH as a medical treatment, Bryon *et al* (2008) claimed that some ethicists continue to view ANH as fundamental nursing care.

Other ethical views were that withholding ANH was to do harm to patients (Konishi *et al* 2002, Bryon *et al* 2008, Ke *et al* 2008a); withholding ANH causes suffering (Bryon *et al* 2008, Van der Riet *et al* 2008); the patient is alive and nurses have an ethical duty to care for the person, which includes providing food and fluids (Konishi *et al* 2002, Bryon *et al* 2008); ANH gives life and hope (Konishi *et al* 2002, Van der Riet *et al* 2008); ANH gives mental support (Ke *et al* 2008a, 2008b); and ANH maintains patient dignity (Konishi *et al* 2002, Bryon *et al* 2008).

The most frequently mentioned ethical argument against ANH provision was that quality of life should be considered over sanctity of life (Bryon *et al* 2008, Ke *et al* 2008a, Van der Riet *et al* 2008). Other arguments were that there is an ethical duty to reduce suffering; providing

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ANH causes more suffering; withholding ANH safeguards a natural death; and providing ANH harms patient dignity (Bryon *et al* 2008, Konishi *et al* 2008).

In addition to the arguments for and against providing ANH, the literature review revealed issues about the ethical deliberation processes surrounding ANH. Three of the studies reported that before making decisions about providing ANH, nurses made judgements about the patient's situation. These judgements then informed ethical deliberation, in which the nurse weighed up concepts such as autonomy, beneficence, dignity, and sanctity and quality of life (Konishi *et al* 2002, Bryon *et al* 2008, Ke *et al* 2008a).

Bryon *et al* (2008) suggested that the judgements made by nurses to inform their decision making, and their ethical arguments for and against ANH, are sometimes incorrect. Bryon *et al* (2008) stated that rather than always being based on sound clinical evidence, nurses' attitudes are sometimes based on incorrect clinical suppositions or mere intuition. Konishi *et al* (2002) and Bryon *et al* (2008) also claimed that many of the nurses' ethical arguments for and against ANH could be refuted by clinical research evidence.

Clinical factors

In addition to socio-professional and ethical influences, nurses' attitudes towards ANH in palliative care were influenced by clinically-based arguments for and against its use (Konishi *et al* 2002, Bryon *et al* 2008, Ke *et al* 2008a, 2008b, Miyashita *et al* 2008, Van der Riet *et al* 2008). There were more clinical arguments in favour of withholding ANH than there were in support of its use. Arguments against providing ANH tended to be more emotive than those for its use. One clinical argument for providing ANH was the convenience of having intravenous cannulae; nurses reported that this was useful for providing palliative medication in addition to ANH (Konishi *et al* 2002, Bryon *et al* 2008). Other arguments in favour of ANH were to provide comfort for the patient (Bryon *et al* 2008, Ke *et al* 2008a, Miyashita *et al* 2008) and prevent pneumonia (Byron *et al* 2008). However, Byron *et al* (2008) later refuted this argument, stating that providing ANH to prevent pneumonia is unsupported by clinical evidence.

The most frequently cited argument against the use of ANH in palliative care was that it causes discomfort (Konishi *et al* 2002, Bryon *et al* 2008, Ke *et al* 2008a, 2008b). Pain associated with peripheral and pulmonary oedema, and ascites that occurs as a result of fluid overload, were mentioned (Konishi *et al* 2002, Ke *et al* 2008a). Other arguments were that the intravenous administration set was a burden to patients (Ke *et al* 2008a, Miyashita *et al* 2008, Van der Riet *et al* 2008), and withholding ANH ensured a more comfortable death (Konishi *et al* 2002, Bryon *et al* 2008, Van der Riet *et al* 2008).

The view that ANH was a futile treatment, was used to justify withholding it (Bryon *et al* 2008, Ke *et al* 2008b, Van der Riet *et al* 2008). This concurs with the General Medical Council's (2010) advice that there is no obligation to provide treatment in palliative care if it is considered futile or burdensome. The view that ANH could be withdrawn because of its perceived futility was an important factor in the landmark court case involving Tony Bland (Wainwright and Gallagher 2007).

Some nurses felt that ANH should be withheld to provide patient comfort (Konishi *et al* 2002, Van der Riet *et al* 2008). The view that dehydration and loss of appetite are entirely normal for patients receiving palliative care and do not cause any suffering was also expressed (Van der Riet *et al* 2008). Others suggested that terminal dehydration can relieve distressing symptoms and reduce patient discomfort (Bryon *et al* 2008, Van der Riet *et al* 2008). Few nurses in Konishi *et al*'s (2002) study mentioned clinical cost as an argument against providing ANH.

In addition to the arguments for and against providing ANH, there was frequent discussion about nurses' knowledge of ANH. It was suggested that while many nurses had adequate knowledge of palliative care (Ke *et al* 2008a, 2008b), they often lacked in-depth clinical knowledge about ANH (Bryon *et al* 2008, Ke *et al* 2008a, 2008b) and the dying process (Ke *et al* 2008a, Van der Riet *et al* 2008). Ke *et al* (2008a, 2008b) suggested that providing ANH in palliative care is often inappropriate. The authors stated that nurses' lack of knowledge about ANH is responsible for their tendency to agree with its provision (Ke *et al* 2008a). Several studies reported that, as nurses gain experience, they are less likely to be in favour of providing ANH to patients who are dying (Konishi *et al* 2002, Bryon *et al* 2008, Ke *et al* 2008b). Furthermore, Ke *et al* (2008b) found that nurses' knowledge and attitudes changed significantly following education on ANH. However, their intentions to provide ANH did not change significantly following such education.

Legal factors

Legal issues were seldom mentioned in the articles reviewed. This was surprising as it seems likely that nurses would consider the law during ANH

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decision making. Perhaps more probable is that nurses, when talking about sensitive end of life issues, avoided mentioning legal issues for fear of sounding callous and uncaring. Where legal issues were mentioned, nurses were concerned about the issues of consent as well as who made the decision to provide or withhold ANH (Konishi *et al* 2002, Bryon *et al* 2008).

Discussion

It is important to note that some of the findings from the literature review have limited generalisability because of the dearth of evidence originating from the UK, United States and western Europe. Of the studies reviewed, two were carried out in Japan and two in Taiwan. The authors of these four studies acknowledged that the culture may have influenced the findings. The authors stated that Japanese and Taiwanese cultures are known to influence nurses' attitudes and medical decision making (Konishi *et al* 2002, Ke *et al* 2008a, 2008b). For example, the frequently mentioned influence of patients' families was said to be expected given that Japan and Taiwan have a strong culture of family decision making (Konishi *et al* 2002, Ke *et al* 2008a). Ke *et al* (2008a) also stated that in Taiwan, nurses' attitudes towards ANH may have been influenced by their cultural view of food and its significance – the belief that 'food comes first for people' (Ke *et al* 2008a). However, irrespective of cultural differences, the suggestion that nurses do not have the competence to deal with decisions relating to ANH is a concern. In this sense, the issues identified by the literature review are important and relevant.

Nurses were found to have adequate knowledge of palliative care (Ke *et al* 2008a, 2008b), yet in-depth clinical knowledge was lacking about providing and withholding ANH, as well as the dying process (Bryon *et al* 2008, Ke *et al* 2008a, 2008b, Van der Riet *et al* 2008). Nurses were found frequently to be influenced by those around them (Konishi *et al* 2002, Bryon *et al* 2008, Ke *et al* 2008a, 2008b, Miyashita *et al* 2008, Van der Riet *et al* 2008), suggesting that they lacked confidence in their abilities and practice. Furthermore, while nurses' attitudes to ANH were influenced mainly by ethical factors, they often struggled with the complex ethical reasoning required to make decisions about ANH. Instead of using sound clinical knowledge to inform their ethical decisions, nurses sometimes turned to personal judgement, intuition or incorrect clinical assumptions (Konishi *et al* 2002, Bryon *et al* 2008). The literature review identified a lack of confidence and competence in the way nurses managed situations surrounding ANH in palliative care (Konishi *et al* 2002, Bryon *et al* 2008, Ke *et al* 2008a, 2008b, Miyashita *et al* 2008, Van der Riet *et al* 2008).

In the UK there is a lack of guidance available for nurses relating to ANH, despite this being a complex and challenging area. Guidance that informs ANH decision making comes from the General Medical Council (2010). However, many nurses are unaware of this information and do not have access to it in the workplace (Ingham 2001). Because the guidance was written with a focus on the medical profession, it may seem less relevant to nurses – there are no equivalent ANH guidelines for nurses (McMillen 2008). While the widely used *Liverpool Care Pathway for the Dying Patient* has an ethos of discontinuing non-essential treatments (Allmark and Tod 2009), it does not preclude the use of ANH. The pathway emphasises that a blanket policy for providing and withholding ANH would be ethically indefensible (Marie Curie Palliative Care Institute Liverpool 2010).

Recommendations

Nurses need to have access to education on the advantages and disadvantages of providing ANH in palliative care. Training should be mandatory for all nurses who provide palliative care. Nurses need to have an understanding of how to incorporate ethical and clinical factors when making decisions. This is termed clinical ethics (Bryon *et al* 2008). Nurses with knowledge of clinical ethics will be better prepared to make decisions about ANH.

With in-depth knowledge about ANH, nurses will have confidence in their practice and the influence of others will be minimised; nurses will be less likely to follow the requests of doctors without question, or to supply or withhold ANH to support relatives before considering the needs of the patient.

Multidisciplinary guidelines and policies relating to ANH decision making in palliative care should be developed. While doctors are often the primary decision makers regarding ANH, nurses who provide palliative care are often faced with the strong emotions of relatives. Guidelines should be available on how best to support nurses to deal with such complex situations.

Nurses should use their communication skills to provide psychological support to relatives. Time and effort should be spent educating patients receiving palliative care and their

relatives about ANH to encourage them to make informed decisions. Attempts should also be made to inform the public about the advantages and disadvantages of ANH in palliative care, as the withholding of ANH may be perceived as being synonymous with euthanasia.

More research should be done investigating nurses' attitudes towards providing and withholding ANH in palliative care, especially in the UK, where evidence is lacking.

Conclusion

This literature review aimed to identify nurses' attitudes towards providing or withholding ANH. It was not possible to conclude whether the majority of nurses are for or against its use in palliative care, as this varies significantly depending on the situation. Nurses' attitudes were frequently influenced by the views of others, as well as ethical, clinical and legal factors. The literature review found that many nurses lacked in-depth knowledge about the appropriate use of ANH in palliative care, which can affect ethical decision making, and professional confidence and competence. It is recommended that more education is provided on the benefits and limitations of ANH in palliative care to inform practice and improve care for patients **NS**

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