

## Letters

### Nutrition, dehydration and the terminally ill

SIR

Gillian Craig (1) has raised some interesting and valid points about nutrition, dehydration and the terminally ill. However, we believe that many of her fears are misplaced because of a misunderstanding of current practice within palliative medicine.

Dr Craig relates her fears concerning the dangers of 'grouping people labelled terminal in institutions'. She adds 'Not everyone referred for terminal care proves to be terminally ill, and no physician should accept such a diagnosis without reviewing the evidence personally'. This statement is as true of the cardiologist and neurologist as it is of palliative care physicians. Referring someone to a hospice for terminal care is not a self-fulfilling prediction. Patients are always reassessed. Many patients referred to a hospice for terminal care are discharged temporarily following an appropriate period of symptom control. Very occasionally patients are discharged home from the hospice for good (four times in the last 15 months we have been referred patients subsequently found to have non-malignant disease). We agree that it would be dangerous to label patients as terminal and then to send them to an institution to wait to die, but this does not reflect the realities of palliative care. Doctors specialising in palliative medicine are not 'therapeutically inactive' doctors, and hospices are not institutions 'oriented towards death'.

Dr Craig is obviously concerned that 'hospice staff' do not use drips enough. From her own experience she has seen that 'many dehydrated patients look and feel a lot better when they are rehydrated'. We cannot argue with that. However, what is true of

many 'dehydrated patients' is certainly not true of many dying patients. Dr Craig cites patient discomfort and distress, and difficulty in turning a patient as reasons given by hospice staff for not siting a drip. The principal reason that a drip is not sited in dying patients is futility.

When patients are symptomatic, palliative care physicians will use artificial hydration. For instance, patients with advanced oesophageal carcinoma will often become thirsty through inability to swallow sufficient fluid - in this case it makes perfect sense to supply fluids artificially. However, when a patient is dying from advanced malignancy, they become anorectic, weak, tired and disabled. A certain amount of dehydration is 'physiological' in the dying process. Putting up a drip on a patient who is dying does not result in any symptomatic benefit. On the contrary, well hydrated patients often develop a very unpleasant 'death rattle' in their terminal phases. Patients with space-occupying lesions in their brains often deteriorate more rapidly if an intravenous drip is started, because of worsening cerebral oedema. In a retrospective analysis of 68 dying patients, Waller *et al* (2) found that level of consciousness did not correlate with the use or non-use of intravenous fluids, which merely demonstrates that there is a difference between the 'acute' patient and the 'dying' patient. Furthermore, many patients died at home. Does this mean that patients dying at home who need sedation should be admitted for intravenous fluids?

Dr Craig worries that if sedated patients are left without hydration for more than one or two days they will become dehydrated. If this condition is allowed to continue she feels that in certain cases we will be 'killing' the patient. This is strong language and completely unproven. If a patient has had to be sedated because of terminal agitation then his or her prognosis is short. If such patients were left alone,

they would become dehydrated because of their delirium. By sedating patients you are relieving their distress, but it is not at all clear that you are shortening their life. Indeed, the conscious and agitated patient may become dehydrated more quickly than the sedated and peaceful one. In either case the patient is more likely to die of his or her underlying disease than of dehydration. Given the uncertainty of survival outcome, but the clear problems associated with intravenous hydration, I do not see how it can be ethically imperative to rehydrate dying patients.

A final cause for concern is Dr Craig's medicalisation of dying. Her experience as a hospital doctor convinces her of the need artificially to hydrate dying patients for fear of accelerating their deaths. We are all going to die. With or without intravenous fluids the result will be the same. Part of what the 'hospice movement' is trying to do, is to get patients and more particularly doctors, to accept when 'active' measures have become futile.

#### References

- (1) Craig G. On withholding nutrition and hydration in the terminally ill: has palliative medicine gone too far? *Journal of medical ethics* 1994; 20: 139-143.
- (2) Waller A, Adunski A, Hershkowitz M. Terminal dehydration and intravenous fluids. *Lancet* 1991; 337: 745.

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