

Dealing with Decreased Oral Intake During the Dying Process



As patients approach death, the need for food and fluid decreases and they often want little or none of either. As hospice professionals, we continue to offer food and fluids but do not try to force food or manipulate the patient into eating and drinking.

If decrease in appetite is a result of nausea and/or vomiting, comfort measures require that we creatively explore those foods that the patient can tolerate and collaborate with the physician about anti-emetics that relieve nausea. Seeking the assistance of a dietician may be helpful. In general, hospice professionals respect the wishes of the patient while providing nutritional options.

Patient and/or family members may be very concerned about decreased oral intake. Family members will often ask, "Is he/she starving?" Our society is one in which food portrays health, life, and social functioning. When patients no longer desire food and fluids, their families and loved ones may view this experience as "the beginning of the end". It is important that we impart to the family that the patient has chosen not to eat, that eating will not prolong survival, decrease weight loss, or reverse weakness, and that lack of food may not be distressing to the patient. (Kaye, 1991, pp 211-212) It is equally important, however, that we address the psychosocial effects of the patient's lack of intake. Patient and family education regarding current research on oral intake for individuals at the end of life and ongoing reassurance can assist the patient/family in accepting the patient's decision, lack of desire for food and fluids, and/or inability to eat.

Many families and health care professionals may also become concerned about the lack of fluids when the patient is actively dying. According to current research, dehydration may not be distressing but actually beneficial to the patient at the end of life. (Woodruff, 2004) Patients usually do not report being thirsty or hungry, and

they very often become agitated when food and fluids are forced. Forced or artificial hydration often increases edema, predisposing the patient to pressure sores and increased respiratory congestion. Dehydration, however, actually has a number of advantages in the dying patient. Dehydration reduces pulmonary secretions, decreases the chances of vomiting, and reduces urinary output, which may decrease episodes of incontinence and/or the need for an indwelling catheter. (Rousseau, 1993; Rousseau, 1992; McCann, Hall, and Groth-Juncker, 1994; Woodruff, 1996) Death without intravenous fluids is often considered a natural death.

Often the only discomfort of decreased fluids may be a dry mouth. A moist washcloth and good mouth care will suffice as comfort measures. Mouth care is done at least every two hours with saliva substitutes and frequent cleansing.

Lemon glycerin swabs can be drying to the mucous membranes and should be avoided. Lip balm should be regularly applied to lips.

Dehydration occurs naturally as part of the dying process. Even though there is little evidence that aggressive nutritional therapy will improve survival or physical symptoms, (Woodruff, 2004) it is important for the hospice professional to support a patient's choice for intravenous hydration and/or tube feedings. For some patients, artificial nutrition and hydration may signify quality of life, individual choice, and cultural and religious beliefs. Removal and/or lack of placement of IV's and/or tube feedings may have negative connotations for patients and families. They may feel as though they are not being properly cared for if these measures aren't supported, and they may feel guilty if they are forced to decline such measures. As hospice professionals, we "accept patients and families where they are". As patient advocates, it is the responsibility of nurses, psychosocial professionals, and spiritual care professionals to educate the patient and family regarding the pros and cons of artificial hydration, assist with the decision making process, and support the patient's and family's choice.

References

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