Clinical Ethics and Nutrition Support Practice: Implications for Practice Change and Curriculum Development

CLINICAL ETHICS AWARENESS involving nutrition support has increased during the past 4 decades because of media attention and public discussion of several landmark cases, including Karen Ann Quinlan, Nancy Beth Cruzan, and Theresa Marie Schiavo, and the results of subsequent court decisions.[1] Yet decisions to start or stop nutrition support for specific individuals remain challenging. Withholding or withdrawing nutrition support is appropriate if the risks and burdens outweigh the potential benefits as perceived by the informed individual, family, or surrogate decision maker. Despite advancements in the field of nutrition support practice, a practice gap remains between appropriate use of nutrition support and other advanced life-sustaining treatments, such as mechanical ventilation and cardiopulmonary resuscitation, based on the individual's wishes.[2-6]

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The goal of this practice application article is to promote the recommendations that are in the literature for integration of clinical ethics in nutrition support practice and to facilitate a consideration for change in curriculum development. This process involves the interdisciplinary care of individual/family/surrogate, including assessments and medical treatments, such as nutrition support. Registered dietitian nutritionists (RDNs) can integrate components of clinical ethics as part of the nutrition care process. The best care requires that treatments are consistent with the values, culture, faith, preferences, and priorities of individuals/family/surrogates, and involves optimum communication and decision-making practices.

DEVELOPMENT OF ACTION STATEMENTS AND PRACTICE APPLICATION

A literature review of the past 5 years identified actions that clinicians and hospitals could use to optimize clinical ethics in nutrition support care.[2-4,7-39] Ten action statements were selected from a list of actions by 22 members of the International Clinical Ethics Section of the American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.) (Figure 1). These nutrition support professionals were selected because they represented international clinicians, educators, and researchers with different levels of experience. A survey was developed to gain understanding of current clinician practices to guide practice application and curriculum development at all levels for entry, undergraduate, graduate, to professional development post-credentialing clinicians.

CLINICAL ETHICS PRIORITIES

The common priorities of the action statements reflect a desire to communicate early with individuals/family/surrogates in order to learn their wishes for life-sustaining therapies and obtain advance directives; and incorporate evidence-based medicine addressing potential benefits vs risk/burdens of therapies, along with a proactive consistent health care team approach. Many health care organizations do not yet have reliable systems to engage effectively with individuals to understand their advance care planning wishes and to record this information in a retrievable, easily accessed location. The first step in this process involves structural empowerment and should be based on the mission, vision, and values of the health care institution, and would require physician engagement and hospital administration support. An example in the intensive care unit for the next step requires quantitative benchmark collection of data for the number of patients with nutrition support, mechanical ventilation, advance directives, family care conferences, and palliative and ethics consults.[2] Development of an institution clinical policy and procedure for ethical decision making for

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Performer of action	Action statements
Clinician	• Prevent ethical dilemmas with early communication with patient, family, and/or surrogate decision maker about patient wishes for life-sustaining treatments for short and long term • Incorporate evidence-based medicine on benefits vs risk/burdens of nutrition support • Include ethical decision making for nutrition support into clinical practice • Achieve early communication with clinicians, patients, and family through family care meetings • Utilize shared decision making and health literacy in nutrition support education
Health care institution	• Establish a process to obtain advance directives, Physician Orders for Life-Sustaining Treatment, and/or begin early discussion of health care wishes • Meet individuals' needs with informed health care decision makers and consistent health care team approach • Develop a proactive, integrated systematic process, including policies and procedures for ethical decision making for nutrition support • Consult or involve palliative care teams early for the critically ill patient or individuals near end of life • Promote interprofessional roles in clinical ethics and communication

Figure 1. Clinician and health care institution action statements.

nutrition support and the health care choices communication process would formalize the recommendations.[1,2] Evaluation of the practice change after implementation of the policy and procedure would be important to determine the satisfaction of clinicians and patients/family/surrogates with the process.

TRANSDISCIPLINARY FUNCTION

RDN involvement in clinical ethics is supported by the Academy of Nutrition and Dietetics with position and practice papers and an ethics action paper,[27,35,40] along with an ethics requirement for recertification each 5-year cycle. Clinical ethics requires an interdisciplinary (physicians, RDNs, nurses, pharmacists, speech language pathologists, social workers, chaplains, and other professionals, as appropriate) process and acceptance of discipline interaction to achieve a consistent team approach with individuals/family/surrogates. Similarities in approach among disciplines would allow for transdisciplinary function, which refers to health care team members performing agreed-upon functions by the most capable and available individual, at the time that the function is required.[41] When traditional roles are blurred or blended, members of the team might assume nontraditional tasks within the limits of their respective scope of practice. Clinician competency with the issue/task is critical, even if theoretically it is within their scope of practice. Recognizing one's own limits and level of expertise is essential, and knowing when to consult with or bring in others to address the issue supports safe, quality patient care. While professionals might share similar goals and priorities, how they actualize these shared goals will likely vary depending on their background, training, professional and personal experience, and areas of focus, as well as connection with the individual/family/surrogate.

EVIDENCE-BASED EVALUATION OF BENEFITS AND RISK/BURDENS OF NUTRITION SUPPORT

The Academy of Nutrition and Dietetics and A.S.P.E.N. have created evidence-based guidelines that evaluate the potential benefits vs risk/burdens of therapeutic nutrition support in a myriad of clinical situations.[5,9,27,35] For individuals receiving active therapy for underlying disease and associated physiologic derangements, these guidelines offer guidance for when and how to use nutrition support. Application of clinical ethics is quite straightforward: nutrition support should be prescribed when the potential benefits outweigh the risk/burdens as evaluated by an evidence-based analysis. Only interventions likely to benefit patients should be undertaken, as assessed by the clinician in collaboration with the family/surrogate that these medical treatments are in line with the patient's preference.

RECOMMENDATIONS FOR NUTRITION CURRICULUM DESIGN

Different approaches to engage, empower, and educate nutrition support clinicians in clinical ethics might be needed for students in the various disciplines. It is important that students develop an understanding of the four main bioethics principles (autonomy, beneficence, nonmaleficence, and justice), along with cultivating their own moral reasoning skills and communication skills with patients and other disciplines.[42] Undergraduate education represents the first opportunity to expose health care professionals to clinical ethics training. Assisting students to develop communication and critical thinking skills is crucial in fostering professionals who are adept at navigating ethical dilemmas in clinical practice. One increasingly popular method of cultivating communication skills is through interprofessional education in which students from two or more disciplines are taught together in order to nurture collaborative practice to deliver patient-centered

care and promote student-centered learning developed in a team-based manner.[42-46] Structuring the education process so that students, interns, and residents can rotate with a palliative care or hospice team, and/or participate in ethics committee meetings, would provide an interprofessional experience with end-of-life issues dealing with nutrition concerns that could help nurture critical thinking about preventing ethical dilemmas. Critical thinking would involve how to help individuals/family/surrogates differentiate the meaning and emotions attributed to food as opposed to medically administered nutrients through tubes, with burdens and risks, involving these medical treatments.[47]

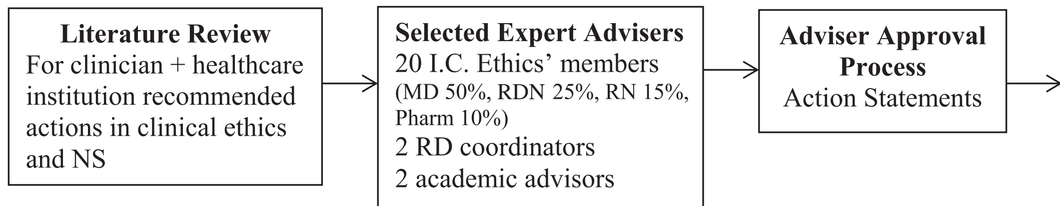
The principles of graduate and professional learning form the conceptual framework for the integration of clinical ethics concepts into a nutrition curriculum. In an ethics module, students have the opportunity to role play different ethical and/or end-of-life clinical situations with other health care professionals. Through role playing and clinical scenarios, students can experience the difficulty in comprehending complex life and death decisions, and how they impact logical/factual and emotional/spiritual decisions. Similar to a medical model, residency programs often provide the perfect clinical setting for continued learning in a structured and supportive manner. Ideally, a program that includes didactic and simulation experiences in addition to a mentored clinical practicum would be beneficial.[48]

INTEGRATION OF PALLIATIVE CARE TRAINING INTO HEALTH CARE CLINICIANS CURRICULUM

Understanding of palliative care principles and application in the clinical process is critical to improve the ethical practice of initiating, withholding, or withdrawing of nutrition support. With increasing professional and public awareness of the need for humanistic care at the end of life, palliative care has emerged as a priority in medical education.[49] Palliative care should not be considered only for an end-of-life focus, but a broader process involving quality of life discussions in difficult situations. RDNs, nurses, pharmacists, and speech language pathologists are recognizing the need to incorporate basic palliative care concepts in their practice. Most practicing physicians did not receive sufficient attention to palliative care in medical school curricula. In conjunction with the overall limited nutrition education in the medical training of physicians, it is not surprising that nutrition issues for the individual who would benefit from palliative care are lacking in everyday clinical practice.[6,50] Ironically, end-of-life care and nutrition support are the two topics that all health care clinicians will encounter personally in their own lives or professionally, regardless of specialty.

Coming to this realization is an important step in preparing, providing, and incorporating a palliative care training curriculum dealing with nutrition issues. Such a program would not only provide clinicians with a better understanding of end-of-life nutrition concepts, but would also address the many concerns and fears of individuals/family/surrogate regarding nutrition and hydration during the final chapters of life. In essence, by promoting improved education and providing beneficial information to all those directly involved with patient-centered care, there would be an increase in individual/family/surrogate satisfaction, as well as decreased medical costs for services that may not be wanted or warranted, based on the

Action Statements Development



Pilot Survey Distribution and Results

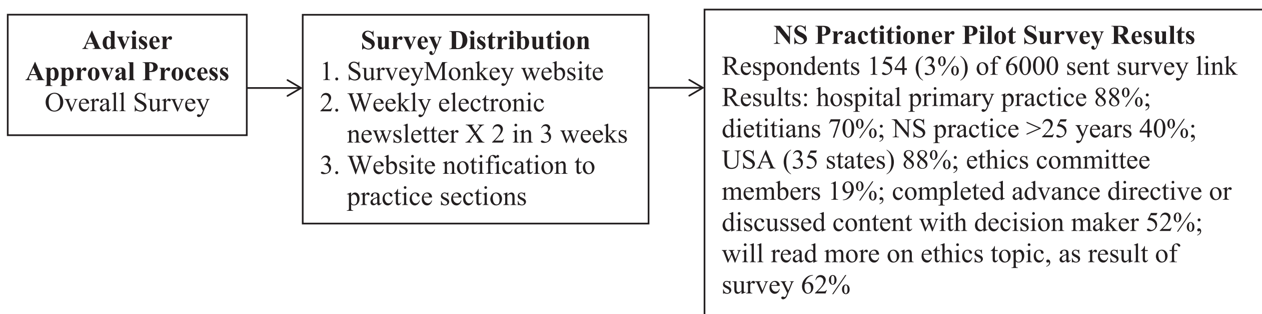


Figure 2. Action statements development and pilot survey distribution and results. I.C. Ethics=International Clinical Ethics Section of the American Society for Parenteral and Enteral Nutrition; MD=medical doctor; NS=nutrition support; RDN=registered dietitian nutritionist; RN=registered nurse.

Table. Indication of responsible party and opportunities of action statements, and the ranking of importance of the action statements

Responsible for action and opportunities	Action statements	Ranking, 1 to 5 (5=highest)
Clinician action statements that could integrate clinical ethics into nutrition support practice	• Prevent ethical dilemmas with early communication with patient, family, and/or surrogate decision maker about patient wishes for life-sustaining treatments for short and long term	3.86
	• Incorporate evidence-based medicine on benefits vs risk/burdens of nutrition support	3.58
	• Include ethical decision making for nutrition support into clinical practice	3.32
	• Achieve early communication with clinicians, patients, and family through family care meetings	2.72
	• Utilize shared decision making and health literacy in nutrition support education	1.53
Health care institution action statements that could integrate clinical ethics into nutrition support practice	• Establish a process to obtain advance directives, Physician Orders for Life-Sustaining Treatment and/or begin early discussion of health care wishes	3.49
	• Meet individuals' needs with informed health care decision makers and consistent health care team approach	3.31
	• Develop a proactive, integrated systematic process, including policies and procedures for ethical decision making for nutrition support	3.27
	• Consult or involve palliative care teams early for the critically ill patient or individuals near end of life	2.67
	• Promote interprofessional roles in clinical ethics and communication	2.27
Clinician and health care institution action statements to educate bedside staff to become more "conversation" ready to addressed end of life issues with patients	• Engage with our patients and families to understand what matters most to them at the end of life	4.44
	• Respect patient's wishes for care at the end of life by partnering to develop shared goals of care	3.75
	• Connect in a manner that is culturally and individually respectful of each patient	2.95
	• Steward this information as reliably as we do allergy information	2.56
	• Exemplify this work in our own lives so that we understand the benefits and challenges	1.29
Measurable goals that could indicate opportunities for improvement in patient-centered care to enhance clinical ethics practice.	• Increase in number of patients on nutrition support with an advance directive on chart	3.58
	• Increase in number of patients with designated decision makers	3.51
	• Increase in number of patients in intensive care unit with family care conferences	2.90
	• Reduction in number of gastrostomy tube placements in patients with advanced dementia, based on defined criteria	2.59
	• Increase in number of critically ill patients with palliative care consults	2.42

individual's quality-of-life goals.[6,51] Any successful palliative nutrition training curriculum would require dealing with ethical issues[49,52] and incorporating a team approach.

RANKING OF ACTION STATEMENTS

Initial application of the recommendations indicated in this article may be limited due to restriction on clinician's care time and institution financial restrictions. A survey was developed and distributed to rank the action statements and provide an indication of the relative importance for implementation. The results were collected (Figure 2). Additional action statements used in the survey were developed from the work of the Institute for Healthcare Improvement (IHI) in their Conversation Ready initiative (Table). The IHI focuses on helping health care organizations to become ready to receive, record, and respect individual's wishes in a reliable way. Five principles were developed that depict actions clinicians believed would be most helpful to engage with individuals to understand their end-of-life care wishes and record this information.[53] The IHI made the decision to continue

the learning process with the formation of the Conversation Ready Health Care Community and an IHI White Paper.[54] The Table presents a ranking of the 10 initial action statements, as well as IHI-developed processes and measurable goals that indicate opportunities for improvement in patient-centered care to enhance the application of clinical ethics. The Institutional Review Board of the California State University, Northridge, deemed this survey study to be exempt from further approval or subject consent.

RANKING VARIATION OF ACTION STATEMENTS

Clinicians caring for adult, pediatric, and neonatal individuals had different rankings for clinician ethics action statements. Pediatric and neonatal practitioners ranked "incorporate evidence-based medicine on benefits vs risk/burdens of nutrition support and include ethical decision making into clinical practice" highest. Conversely, adult practitioners ranked "prevent ethical dilemmas with early communication with patient, family, and/or surrogate decision maker about patient wishes for life-sustaining treatments for short and long term" highest. When a child cannot or will not eat because of illness or a surgical condition, parents will agree to, and often insist on, any technique or plan that enables nutrition to be administered to their child. It is of paramount importance to include the child in this dialogue, dependent on their level of understanding. The pain and discomfort of any proposed procedure must be considered in the context of the child's illness and overall prognosis. *End of life* is not a commonly used term in pediatric-aged individuals. This further complicates care for children and their parents who must confront many questions that arise in the context of a life-ending illness and hospitalization.

American and international practitioners also had different priority rankings for health care institution action statements. Respondents in the United States selected "establish a process to obtain advance directives, Physician Orders for Life-Sustaining Treatment and/or begin early discussion of health care wishes" as the highest action statement. This is in comparison to respondents outside of the United States who selected "develop a proactive, integrated systematic process, including policies and procedures for ethical decision making for nutrition support" as their highest action statement. There may be several reasons for the difference in rankings of health care institution action statements. These might include variation in customs, religious beliefs, individual principles, and traditions of the treating team, individuals/family/surrogates. Countries may vary in the approach to health care decision making, from patient/family-centered to physician-centered.[41] In developing countries, lack of both financial and human resources can lead to less availability of health care professionals

to deal with ethical dilemmas, lack of structure to provide an adequate environment to receive relatives and family, and, most probably, scarcity of health care professionals with specific training, such as palliative care to deal with such situations.[55]

RECOMMENDATIONS

It is important that clinicians collectively, from all disciplines, focus their efforts on the establishment of clinicians' actions and institution processes that incorporate the identified actions presented in this article. Prioritizing the implementation of these actions can vary, depending on the specific population and country. The action statements will help address future education programs, materials, and articles in nutrition journals, along with curriculum guidance on the topic of clinical ethics and nutrition support.

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