



APM POSITION STATEMENT ON THE PROVISION OF CLINICALLY ASSISTED HYDRATION AT THE END OF LIFE

(Drafted May 2017; updated July 2018)

Key Points:

- Hydration is a key requirement which should always be considered at the end of life
- Assessment of a person's need for artificial hydration should be an individualised and ongoing process
- Decisions regarding artificial hydration should be discussed carefully with patients and their relatives

Context

Clinically-assisted hydration (CAH), also known as medically-assisted hydration, refers to the provision of fluid via a nasogastric tube, percutaneous endoscopic gastrostomy (PEG), radiologically inserted gastrostomy (RIG), intravenous infusion, or subcutaneous infusion (and occasionally other routes of administration).¹ Under current legislation CAH is regarded as a form of medical treatment.² It does not refer to simple assistance with the act of drinking.

Why is this important?

The provision of CAH at the end-of life is one of the most contentious issues in medicine, and indeed within the general population.³ The reasons for contention include the distinct lack of evidence for or against CAH,^{4,5} the disparate opinions of healthcare professionals about CAH, and the generally positive opinions of patients and their carers about CAH (and the generally negative opinions about withholding or withdrawing CAH).⁶

What are the benefits and risks to patients and families?

All decisions about CAH should follow careful consideration of the individual circumstances of the patient, and focus on reaching the decision that is right for that patient. The decision must consider the patient's (and carers) views, and the patient-specific benefits, burdens and risks of CAH.¹ In some cases, there is a clear rationale for starting CAH, e.g. patients with symptomatic dehydration

(patients with thirst as opposed to patients with dry mouth). Equally, in some cases, there is a clear rationale for not starting CAH, e.g. patients with symptomatic cardiac failure or patients expected to die within hours or days. Nevertheless, in many cases there is a less clear rationale for either starting or not starting CAH.

What is the regulatory view?

It should be noted that the General Medical Council (GMC) guidance on end-of-life care states that “when the benefits, burdens and risks are finely balanced, the (*competent*) patient’s request (*for CAH*) will usually be the deciding factor”.¹ Moreover, the GMC guidance states that an incapacitated patient’s previously expressed views carry a similar weight to those of a competent patient’s currently expressed views.¹

As stated, CAH is regarded as a form of medical treatment, and it is important that the patient is regularly monitored, since the benefits, burdens and risks of CAH may well change over time.¹ The latter applies not only to those patients treated with CAH, but also those patients not treated with CAH. The decision to not provide CAH should be made on clinical grounds, and not for practical or economic reasons.

References

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