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ESPEN Guideline

ESPEN practical guideline on ethical aspects of medical nutrition therapy

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SUMMARY

The provision of medical nutrition therapy (MNT) is a medical intervention that requires an indication, a therapeutic goal, and the consent of the patient. The decision-making process surrounding MNT often involves complex ethical considerations. The aim of this guideline is to provide practical recommendations on an ethical approach to the decision-making process in clinical nutrition. This practical guideline was developed by an international multidisciplinary working group. The practical, solely consensus-based guideline is based on and updates the 2016 ESPEN Guideline on Ethical Aspects of Artificial Nutrition and Hydration, which has been shortened, supplemented with flowcharts, and expanded to include 3 additional ethical statements in palliative care and 1 new statement concerning human rights in clinical nutrition. Two Delphi rounds and a consensus conference were held to reach consensus. The guideline offers a critical summary for clinicians and caregivers regarding the ethics of MNT in special situations, describes common ethical dilemmas, and proposes an algorithm for the decision-making process. The provision of MNT must be undertaken in the patient's best interests, for

Abbreviations: CFO, comfort feeding only; DRM, disease-related malnutrition; EN, enteral nutrition; ICU, intensive care unit; MCF, minimal comfort feeding; MNT, medical nutrition therapy; NST, nutrition support team; PN, parenteral nutrition; QOL, quality of life; UWS, unresponsive wakefulness syndrome; VS, vegetative state.

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their benefit, improvement, or cure. MNT should not expose the patient to disproportionate or unjustifiable risks, and must be indicated in line with current scientific data and guideline recommendations. If the benefit seems clear to the health care professional, the MNT must nevertheless be approved by the patient, who must be adequately informed of the aim and consequences. This guideline places particular emphasis on end-of-life issues, palliative medicine, dementia, and specific scenarios such as nursing care and intensive care. In a multicultural and pluralistic society faced with decisions to feed sick patients in special conditions, it is imperative that the reasoning and the course of action in clinical nutrition are presented in accordance with good clinical practice, adhering to ethical principles.
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1. Introduction

Clinical nutrition is recognized as an interdisciplinary field of applied science concerned with providing nutritional care to those in need through medical nutrition therapy (MNT) [1,2]. This includes oral nutrition supplements, enteral nutrition (EN), and parenteral nutrition (PN). The latter two have traditionally been referred to as “artificially” administered nutrition [3]. MNT makes it possible to feed all ill patients unable to ingest food and fluids. As a discipline, clinical nutrition aims to apply the principles of nutritional care to ensure balanced nutrition and modulate other biological functions, thereby positively influencing an individual's homeostasis, health care treatment, and outcomes [1,2,4].

Malnutrition is what best defines the domain of knowledge and practice of clinical nutrition [1]. It is acknowledged that the term ‘disease-related malnutrition’ (DRM) is to be superseded by ‘undernutrition in adults' in accordance with the terminology stipulated in the addendum to the International Classification of Diseases, 11th Revision, scheduled for implementation in 2027 [5]. It is evident that MNT plays a pivotal role in preventing starvation and inadequate feeding. Consequently, it is a crucial component in the treatment and prevention of DRM in a clinical context [6]. Its impact on disease and quality of life (QOL) of patients is unequivocal.

The nutritionDay survey yielded unequivocal data concerning the risks of mortality associated with inadequate feeding in a hospital setting [7–9]. Patients who consume less than a quarter of their usual meal on nutritionDay exhibit a twofold risk of mortality (OR 2.10, 95% CI 1.53–2.89) or a threefold risk if they do not consume any food (OR 3.02, 95% CI 2.11–4.32) [9]. A mere 25% of patients who do not consume any meal on nutritionDay receive MNT. This finding has been corroborated in other international studies [10]. There is also clear data from randomized controlled studies about the benefits of individualized MNT in patients who are at risk or malnourished [11,12]. Thus, appropriate screening, diagnosis, and assessment of DRM, as well as the definition of a nutrition plan and the subsequent administration of MNT, are essential medical requirements and ethical obligations to prevent harm. Access to nutritional care is considered by scientific societies as a human right, intrinsically linked to the rights to health and food [4,13]. This means that patients should benefit from screening, diagnosis, nutritional assessment, with optimal and timely nutritional therapy in order to overcome malnutrition-associated morbidity and mortality, while reducing the rates of DRM regardless of location [14].

MNT facilitates the provision of nutrition to patients who are incapacitated and unable to ingest food or fluids. Nevertheless, this practice gives rise to ethical dilemmas. Furthermore, specific circumstances (e.g., end of life) and particular contexts (e.g., religion and cultural aspects) have given rise to concerns and debates surrounding the ethical implications thereof. It is imperative to recognise that ethics constitutes the foundation for such debates and raises awareness among the scientific and clinical community. It is regarded as the discipline that addresses these questions in the clinical context through interdisciplinary reflection. In this context, clinical ethics is concerned with the obligations of moral nature that govern the practice of medicine. It is central to the conceptualisation of problems and the elucidation of essential values in clinical practice [15–17]. It is influenced and responsive to the technological and legal environments.

This guideline is intended to provide practical recommendations to assist clinicians in incorporating an ethical approach into the decision-making process in clinical nutrition, concerning MNT. The objective is to provide a useful tool for decisions at the bedside and to encourage further interest in establishing ethical reflection in this crucial field of medicine.

2. Methodology

The present practical guideline consists of 40 statements and is primarily based on the 2016 ESPEN guideline on ethical aspects of artificial nutrition and hydration [18]. The 2016 guideline was developed according to the standard operating procedure for ESPEN guidelines and consensus papers with modifications [19]. For further details on methodology, see the full version of the ESPEN guideline [18].

This practical guideline addresses the ethical aspects of clinical nutrition practice, but it does not aim to generate scientific-level evidence, as is done in any other clinical guideline. Indeed, the ethical approach questions human behavior, whether actions are good, bad, or just, and it is in this sense that a guideline such as this cannot claim to generate a level of evidence on the subject. Due to the nature of the topic, there are no randomized controlled trials and therefore no evidence in the traditional sense. Consequently, given the specific nature of the subject matter, there is no necessity to employ the methods customary in the clinical field when evaluating the existing literature. Instead, the objective is to provide guidance on how to identify an ethical problem and how to analyze ethical issues in the field of clinical nutrition. Thus, this guideline is an expert and solely consensus-based guideline. The guideline focuses on adults; ethical aspects may differ in children and adolescents.

The present guideline was developed by an international expert group representing different professions and backgrounds in ethics, including memberships in ethics committees and long-standing experience in clinical nutrition. Detailed ethical backgrounds are provided in Appendix A.

The members of the working group had declared their individual conflicts of interest according to the rules of the International Committee of Medical Journal Editors (ICMJE).

Between 4th July and 8th August 2025, an online voting (Delphi round) on initially 42 statements was performed using the guideline-services.com platform. All ESPEN members were invited to agree or disagree with the statements and to provide comments. A first draft of the guideline was made available to the participants

on that occasion. Twenty-two statements reached an agreement of >90%, 18 statements reached an agreement of 75–90%, and two statements reached an agreement of <75%. Statements with an agreement >90% (indicating a strong consensus, see Table 1) were directly passed [20]. The statements were revised according to the comments, statements with major revisions in wording and/or <90% agreement, in total 31 statements, entered a second Delphi round, which took place between 22nd August and 8th September 2025. The statements were again revised according to the commentaries, if available, and eight statements were discussed and voted on again during a consensus conference, either due to major changes or due to a low percentage of agreement. The consensus conference took place on 14th September 2025 during the ESPEN congress in Prague. During the consensus conference, one statement reached an agreement of >90%, and six an agreement of 75–90%. One statement was omitted due to a low percentage of agreement, resulting in a total of 40 statements. During the consensus conference, some general aspects were discussed and voted on, resulting in the use of "wish" instead of "will", "nutrition support team, and in the absence, physician and other health care professionals" to describe professionals caring for patients with medical nutrition, and "forced feeding" instead of "enforced feeding" throughout the document. It was also decided to remove any tabular presentation of religious aspects from the present document and instead refer to the 2016 guideline.

3. Ethical framework

This guideline approaches nutritional care ethics as a systematic normative reflection, based on a comprehensive, multicultural, and evolving framework of interdependent values, principles, and actions that can guide health care professionals in the decision-making process [21]. This practical guideline considers ethics as a dynamic basis for the guidance of clinical nutrition, referring to the four ethical principles of autonomy, beneficence, nonmaleficence, and justice.

When oral intake of food and liquids is not possible anymore or does not adequately provide nutrients, and MNT has to be considered, we are confronted with a medical intervention that requires specific rules (Fig. 1, Fig. 2).

Statement 1.

Prerequisites and integration of ethical, cultural, and spiritual competencies into clinical decision-making for MNT involve.

1) understanding that MNT is a medical intervention requiring a clear indication and defined therapeutic goal based on evidence-based nutrition,
2) application of a patient-centered and shared decision-making process grounded in the ethical principles of autonomy, beneficence, non-maleficence, and justice,
3) implementation of a nutrition support team (NST), and in the absence of, the physician and other health care professionals that upholds good clinical practice principles,
4) consistency with the values, culture, faith, preferences, and priorities of the patient or expressed on the patient's behalf by relatives or surrogate decision makers,
5) emphasizing clinician compassionate and empathetic communication skills with patients, relatives, or surrogate decision-makers,
6) promoting the importance of advance care planning and individual communication with a designated decision maker.

Consensus 89% agreement.

Commentary.

In order to approach the ethical issues and dilemmas (i.e., there is a conflict between values or principles) in MNT, the four principles approach is recommended (see Statement 2).

According to different laws in the countries, the clinician may be a physician or another member of the NST.

Statement 2.

The four ethical principles of respect for autonomy, beneficence, nonmaleficence, and justice are internationally acknowledged. They are interrelated and have to be applied in the act of decision-making for MNT.

Strong consensus 100% agreement.

Commentary.

MNT is carried out in the patient's interest, for their benefit, improvement, or cure [17] (Fig. 3, (Statements 3, 10, 13–19).

Considering this ethical framework, four equally weighed arguments must guide the way in which the reasoning and the course of action are presented in clinical nutrition. They are interrelated and must be considered jointly in clinical decision-making, where they may at times be in tension and require careful balancing.

1) MNT is carried out in the patients' interest, for their benefit, improvement, or cure, and should be continuously monitored.
2) MNT should not expose the patient to minimal or any risks (*Primum non nocere*).
3) If the benefit seems clear to the NST and in the absence of, physician and other health care professionals, MNT must nevertheless be approved by the competent patient, or authorized representatives, who must be informed of the aim and consequences
4) MNT must be in line with current scientific data and guideline recommendations.

This guideline approaches ethics in the use of MNT as a systematic process, based on a comprehensive framework of interdependent principles, multicultural values, and actions that can guide clinicians in the decision-making process [22].

This practical guideline considers ethics as a dynamic basis for guidance in the use of the ethical principles of autonomy, beneficence, nonmaleficence, and justice. The four principles of ethics are interrelated and must be considered jointly in clinical decision-making. Emphasis is placed on clinicians exhibiting compassion and empathy in health care that creates an environment where interconnectedness with patients, relatives, and surrogate decision makers can flourish. The importance of advance care planning is encouraged [21,23,24].

3.1. Respect for autonomy and consent

Statement 3.

Autonomy does not imply a right to receive any treatment a patient requests if that treatment is not medically indicated.

Strong consensus 96% agreement.

Commentary.

Autonomy designates that all persons should be able to make rational decisions and moral choices, and everyone should be allowed to exercise their intact decisional capacity for self-determination, unless the person lacks capacity. A competent

Table 1
Classification of the strength of consensus.

Strong consensus	Agreement of >90% of the participants
Consensus	Agreement of >75–90% of the participants
Majority agreement	Agreement of >50–75% of the participants
No consensus	Agreement of <50% of the participants

According to the AWMF methodology [20].

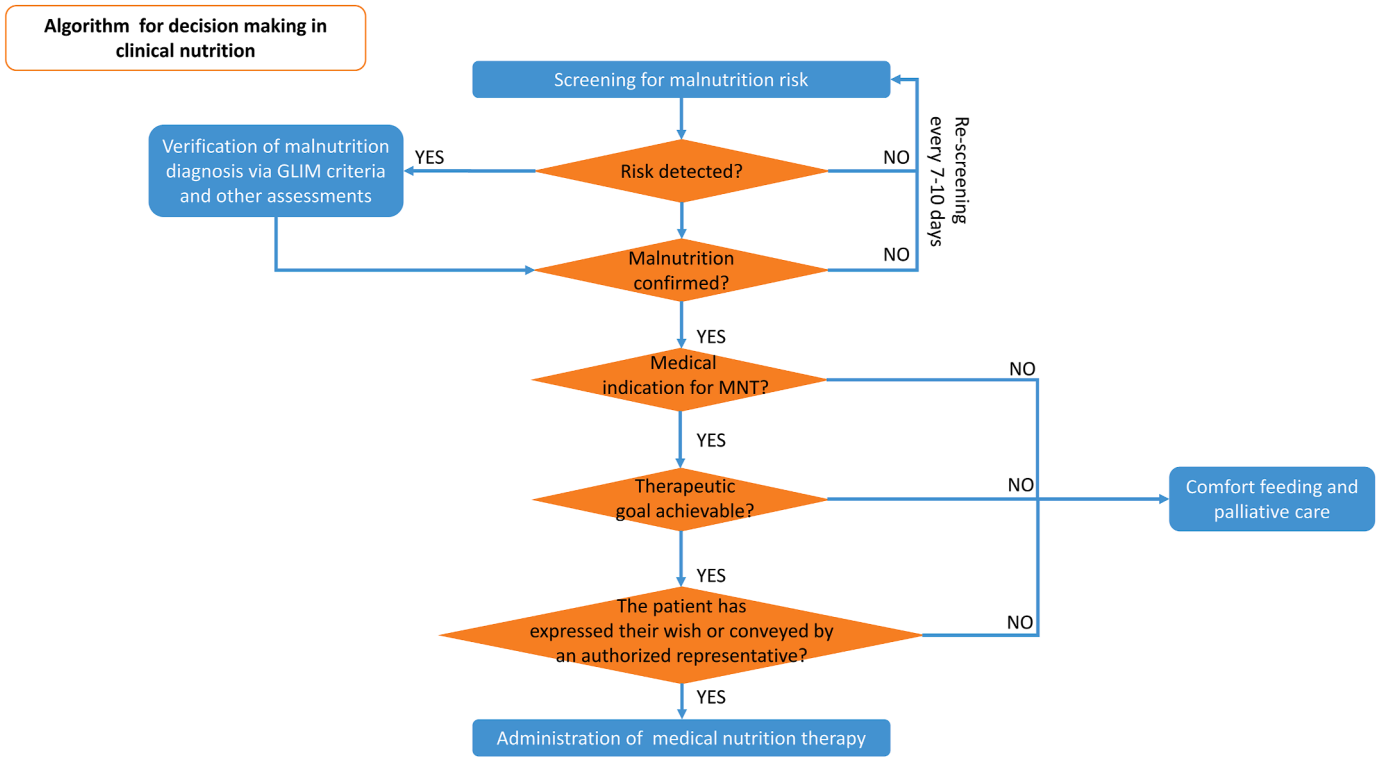

Fig. 1. Algorithm for decision making in clinical nutrition. Abbreviation: GLIM, Global Leadership Initiative on Malnutrition.

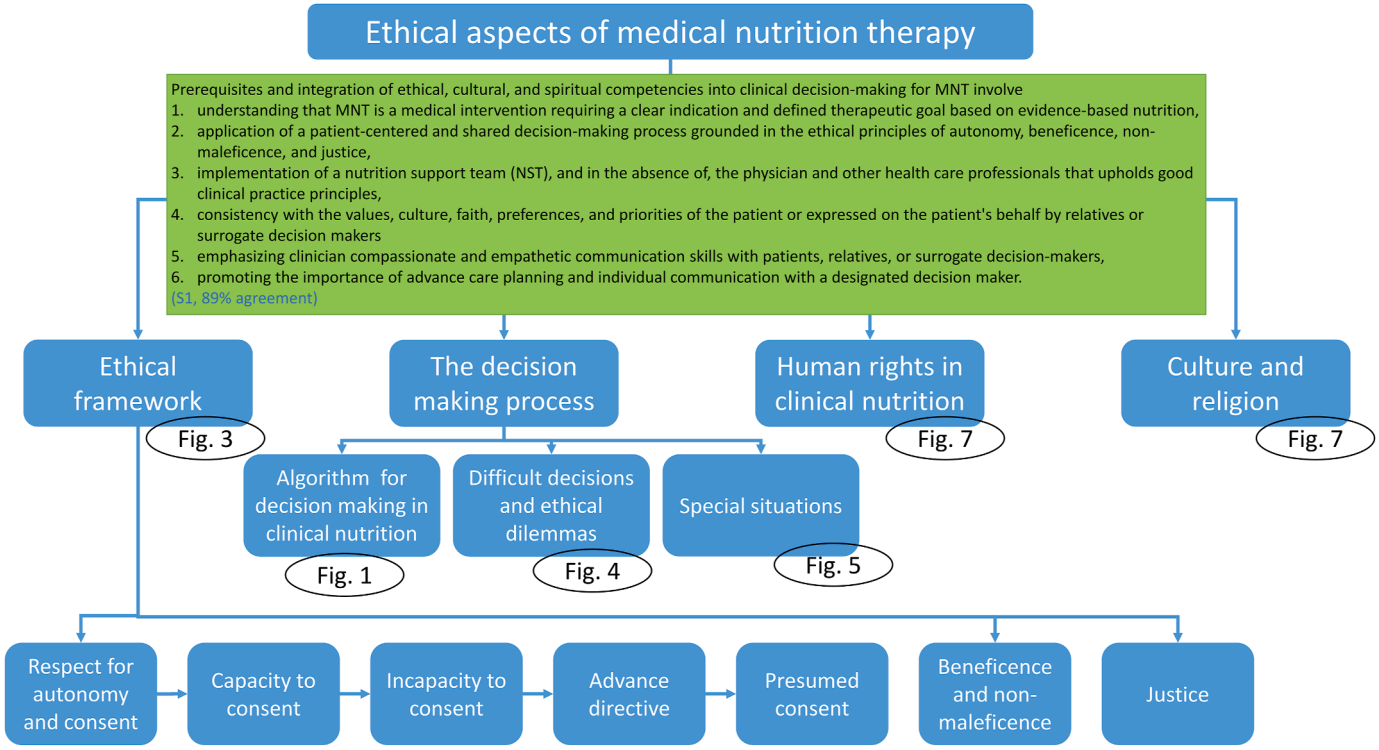

Fig. 2. Ethical aspects of medical nutrition therapy (overview). Abbreviations: MNT, medical nutrition therapy; NST, nutrition support team.

patient in the context means cognitively intact and well-informed about the consequences of the decision [17,25].

Respect for the patient's autonomy is fundamental to patient-centered care. The patient has a say in the health care process to indicate what is in their own interests, based on their desires and values. Respect for autonomy requires the NST and, in the absence of, physician and other health care professionals to effectively communicate medical information and treatment options that are

Fig. 3. Ethical framework and ethical principals. Abbreviations: MNT, medical nutrition therapy; NST, nutrition support team; QOL, quality of life.

necessary for the patient or authorized individual representing the patient's preferences to exercise self-determination and supports informed consent. An autonomous patient may refuse any treatment, including life-sustaining therapy, but cannot demand a treatment that lacks medical indication. If the issue cannot be resolved, arrangements should be made for the patient to be transferred to another care team, and if necessary, to another facility. The safe transfer of care will prevent the potential charge of abandonment.

Context in the therapeutic communication which is built on competent and compassionate care includes 1) clarifying patient preferences on treatment options and goals of care; 2) effects of medical problems, interventions, and treatments on patient's QOL with awareness of individual biases on what constitutes an acceptable QOL; 3) and incorporating many factors that include family, cultural, spiritual, religious, economic, and legal aspects [3].

Statement 4.

As with any other medical intervention, patients and their authorized representatives must be informed about the nature, purpose, and scope of MNT, including potential complications and risks.

Strong consensus 100% agreement.

Commentary.

The information must include alternative treatment options (i.e., alternative routes of nutrition), as well as withholding MNT and its biological consequences. This information should be given

in a decision-making process. In case of surrogates, an unbiased counsel of the NST and in the absence of, physicians and other health care professionals may be helpful [26,27].

Patient information should be neutral, weighing the benefit and harm. Any instrumentalization of the patient for informed consent has to be avoided. In doubtful cases, an additional independent witness should be involved.

The ethical principles of informing a patient are violated when the decision-maker is biased by opinions and beliefs. For instance, in a situation where the patient is unconscious and the decision-maker is urged to act otherwise by relatives or surrogates, saying that the patient "may die of hunger or thirst". Here, as in other situations, wording has to be chosen in a careful and prudent way [18].

3.1.1. The patient's right

Statement 5.

The wishes of an adult patient who is capable of providing informed consent and has decision-making capacity has to be respected in any case.

Consensus 88% agreement.

Commentary.

The basic requirements of informing the patient and obtaining their consent should be adhered to very carefully in MNT. MNT is a medical intervention and requires the informed consent of the patient [28] or the consent of the authorized representative (parents, care-giver, custodian or attorney). In a case of automatic entitlement of representation, the representative should be selected according to the provisions of the respective laws in various countries.

3.1.2. The patient's capacity to consent

Statement 6.

Even if the patient is not legally competent in accordance with civil law, they might be still capable of expressing their wishes and participating in the decision-making process.

Strong consensus 90% agreement.

Commentary.

For persons who cannot exercise their autonomy as they do not have the capacity to consent, there are usually legal representatives to play a decision-making role. Persons who are incapable of consent are persons legally not entitled to give consent (minors), or persons who are incapacitated because of their mental disability or disease. Incapacity due to disease might be in an acute situation due to sepsis or stroke, or on a long-term basis. Both require a different approach [29]. Nevertheless, even persons who are legally not capable of giving consent have the right to express their wishes, and their objection to a medical intervention should be taken into account. In any case, MNT is a medical intervention and requires a predefined achievable treatment goal and the informed consent of the competent patient. It is recommended to start MNT as a time-limited treatment, if it is not beneficial, it should be stopped in line with the wish of the patient.

3.1.3. The patient's incapacity to consent

Statement 7.

In case a patient is unable to give consent and make judgments, the representative or surrogate (authorized according to different rules depending on the country's law and practice) make the decision. The representative has to communicate and care for the implementation of the presumed wish of the patient. If the representatives' decision is delayed, MNT should be started according to evidence-based medical indication.

Strong consensus 91% agreement.

Commentary.

In the case of a patient who is unable to provide consent, one should first determine whether the patient's consent to MNT was provided in advance, for instance, verbally or in a written advance health care directive, or was explicitly not provided or refused [30,31].

3.1.4. Advance directives

Statement 8.

Patients are authorized/encouraged to establish an advance directive or a living wish according to the specific laws in their countries. Certain requirements have to be fulfilled to ensure validity. Valid advance directives must be respected according to the country's laws and by the NST, and in the absence of, the physician and other health care professionals.

Strong consensus 93% agreement.

Commentary.

In the situation that a patient has lost the capacity to consent, previously expressed wishes have to be taken into account. Wishes expressed in advance can take various forms. For example, if the patient has confided their views to a relative, close friend, or other persons of trust, this can be documented in order to establish proof of their (presumed) wish. A representative can also be appointed to bear witness to and pass on the patient's wishes when the patient is incapacitated and cannot express his wishes. A patient can refuse a treatment in an advance directive. They cannot ask for a specific treatment if there is no medical indication for this treatment. Nationally promoted and established advance care planning programs are urgently needed [32–34].

3.1.5. Presumed consent

Statement 9.

In the absence of a clear and applicable statement of the patient's wish in a specific situation, decisions must be guided by the patient's presumed wish. The patient's authorized representative is requested to communicate the patient's presumed wish.

Strong consensus 82% agreement.

Commentary.

Cues expressed by the patient must be adequately documented in writing. Communication with relatives, NST, and in the absence of, physician and other health care professionals, must be included when they disclose important aspects that will help to clarify the patient's presumed wish.

Decisions about MNT made on the basis of presumed consent should preferably be made in consensus by all involved persons in order to ensure widespread acceptance of the proposed measure. The starting point is the patient's self-determination and autonomy [18].

Statement 10.

A competent patient has the right to refuse a treatment after adequate information, even when this refusal would lead to their death.

Strong consensus 93% agreement.

Commentary.

The patient is able to give their consent and make a judgment when they can see the benefits, risks, and scope of the intervention or when no treatment is instituted, and the patient is able to make an autonomous decision. The decision to apply MNT is simple from the intellectual point of view, yet a complex emotional issue. The patient's ability to consent should, in principle, be reviewed and renewed by the NST, and, in the absence of, by the treating physician and other health care professionals. This should be documented in detail. The focus should be on the psychological or legal point of view to make a decision. In doubtful cases, a

psychiatric or neurological consult may help to decide whether the patient is able to make a sound judgment [18].

3.1.6. Quality of life

Statement 11.

QOL must always be taken into account in any type of medical treatment, including MNT.

Strong consensus 93% agreement.

Commentary.

While for oncological patients, well-established tools to assess QOL are available [35], widely accepted instruments for patients with cognitive impairment, suitable for use in clinical routine, do not exist in a satisfactory way currently. Nevertheless, even the patient whose competence is largely impaired gives clues as to their perception of QOL by appropriate expressions or statements. Also, the patient who is unable to give consent or make a judgment should be informed about the proposed measures; the communication should be aligned with their comprehension abilities. The patient's statements or reactions should be also taken into account as appropriate expression of quality of life.

Statement 12.

Whether a patient removes a feeding tube because the foreign object bothers them or because they wish to express their refusal of "life-preserving" nutrition must be interpreted according to the patient's previous statements, values, and life decisions.

Strong consensus 95% agreement.

Commentary.

In any case, one should avoid deviating from a decision previously made by the patient in autonomous condition, merely because one is operating on the speculative notion that, in case the patient is not able to make a decision, in the present situation, the patient would probably make a different decision. However, if a patient, unable to give consent or make a judgment, does clearly, persistently, and explicitly express refusal of nutritional therapy, this treatment should not be used. However, it is mandatory to establish the reason for this persistent refusal. For example, is it grounded on symptoms that can be overcome with another form of nutritional administration [18]?

3.2. Beneficence and non-maleficence

Statement 13.

If the risks and burdens of a given therapy for a specific patient outweigh the potential benefits, then the clinician has the obligation not to provide (withholding) the therapy.

Strong consensus 97% agreement.

Commentary.

Health care personnel have the obligation to maximize potential benefits for their patients while at the same time minimizing potential harm for them ("*Primum non nocere*"). Still, there is a distinction between beneficence and nonmaleficence as those two principles have clear and different obligations [17].

In maximizing potential benefits, health care personnel have to follow professional obligations and standards: they have to provide appropriate treatment following a medical indication, including MNT. Each decision has to be taken on an individual level. This means that they have to take into account the "overall benefit", the possible results of the treatment in regard to the disease, the QOL, and the psychological and spiritual well-being [36]. Any disproportionate treatment has to be avoided (Statements 13–18).

Prolonging of life may never be the sole goal and always has to be put in relation to the well-being of the patient. Prolonging of life may never turn into prolonging the dying phase. Withdrawing or withholding a treatment that provides no benefit or has become disproportionate is, from an ethical and a legal point of view, the same. However, it has to be emphasized that if a therapy is being stopped, standard care or palliative care – so called "comfort" care - still has to be provided to the patient [37].

Statement 14.

Even when MNT and hydration will be stopped, standard care to maintain the best possible QOL for the patient has to be maintained.

Strong consensus 97% agreement.

Commentary.

Applied to MNT, there are many indications for administering it that are beneficial and prolong life: in particular, patients in short-term critical care, cancer [38], patients with gastrointestinal disease, patients with a chronic neurological disease, or patients with a disorder of unconsciousness [39].

For many other conditions, according to the current medical literature, there is evidence that it is not beneficial as the risks, potential complications, and burdens outweigh the benefits. In these cases, MNT should not be provided. The decision to administer or withhold MNT should never limit offering palliative care to maximize comfort and QOL to the patient.

Statement 15.

MNT should be aligned in accordance with a realistic and individualized treatment goal, the patient's wishes, and the clinical assessment by the NST and in the absence of, physician and other health care professionals.

Strong consensus 100% agreement.

Commentary.

The patients should always be viewed in the context of the achievable or indicated medical options as well as social and cultural values. An individual's nutrient requirements can be fully covered by EN as well as PN. However, other needs like the enjoyment of food and social aspects of feeding, including personal human attention, are not satisfied by these routes of food supply, and should not be neglected as such [38].

Statement 16.

Medical treatment may serve the purpose of prolonging or preserving life, even if this requires accepting a temporary reduction in QOL. It may also serve the purpose of enhancing or maintaining QOL, even if this results in a shorter remaining lifespan. The decision to initiate, continue, or withdraw MNT must be based on individual clinical judgement in view of these goals.

Strong consensus 100% agreement.

Commentary.

Once the goal of treatment is defined, the NST and, in the absence of, physicians and other health care professionals may suggest suitable methods to achieve this goal, even accepting a temporary reduction of QOL. Medical interventions are intrinsically associated with advantages and disadvantages or risks. From the medical point of view, one should employ the method that is effective and is likely to achieve the desired goal. The method should be associated with the lowest risk of potential harm. The risks and burden of MNT regarding the creation of access, the volume of fluid, and the substrates to be administered should be included in these considerations. When bridging an acute and reversible disease or in patients with a permanent condition, these aspects may be rated very differently.

Statement 17.

If the feasibility or expected benefit of MNT is uncertain, a time-limited trial may be appropriate. If complications arise or the intended goals are not achieved, the therapy should be discontinued.

Strong consensus 96% agreement.

Statement 18.

The ongoing medical justification for MNT must be reassessed at regular intervals, based on the patient's clinical condition.

Strong consensus 100% agreement.

Commentary.

As the patient approaches the end of their life, the administration of food - specifically adapted to their needs in terms of calories and nutrients - becomes increasingly insignificant.

When the indication for MNT no longer exists (especially in case of no efficacy, therapy-resistant complications, or the immediate dying process), the clinician should be prepared to discontinue the MNT and communicate this decision clearly to the patient or their representative and relatives, as well as the NST and in absence of, physicians and other health care professionals. According to different laws in the countries, the clinician may be a physician or another member of the NST [18].

3.3. Justice

Statement 19.

Every individual is entitled to have access to the best care available. Resources have to be distributed fairly but not necessarily equally without any discrimination. On the other hand, treatments which are futile or low yield and only prolong the suffering or the dying phase have to be avoided. In regard to limited resources, there has to be proper use of ethically appropriate and transparent criteria.

Strong consensus 96% agreement.

Commentary.

Futility means a medically ineffective or low yield intervention. The principle of justice refers to equal access to health care for all. Limited resources, including the time health care clinicians and caregivers devote to their patients, have to be evenly distributed to achieve a true benefit for all the patients [14,40]. Individual accommodations need to be provided in order to achieve similar outcomes. All the more, expensive nutritional therapies should always be, like any other therapy, provided solely when indicated. However, undertreatment may never be the result of containing the growing costs of health care.

4. The decision-making process

Three consecutive questions guide the administration of MNT (Fig. 4).

1. Is there a medical indication for MNT?
2. Is the therapeutic goal achievable?
3. Has the patient expressed their wish or been conveyed by the legal representative?

There is international agreement that the integration of ethical, cultural, and spiritual competencies into clinical decision-making regarding MNT is important [18].

4.1. Difficult decisions and ethical dilemmas

4.1.1. Disagreement and tensions among decision makers

Statement 20.

To achieve a mutually acceptable solution regarding nutritional support, one should utilize all options from diet counselling to MNT. This also includes, if necessary, obtaining a second opinion, a case discussion in ethics, clinical ethics counselling, or obtaining the recommendations of a clinical ethics committee.

Strong consensus 100% agreement.

Commentary.

This applies in particular to situations involving patients who lack decision-making capacity, when advance directives are ambiguous, or when either the patient or a relative is demanding a futile or low-yield therapy. Complex decisions or disagreement often arise from differing interpretations of what constitutes an appropriate or realistic therapeutic goal and, consequently, whether a medical intervention is indicated [41]. Even the presumed wish and perceived well-being of a patient may be interpreted differently by those involved in the decision-making process [42,43]. In these situations, involving a clinical ethics committee for case discussion and counselling may be helpful, particularly in the absence of an advance directive.

Statement 21.

If there is no medical indication, no realistic prospect of achieving a treatment goal, or if valid consent is lacking, MNT should be discontinued. This decision may cause emotional or ethical conflict among relatives or within the NST/physicians and other health care professionals.

Strong consensus 91% agreement.

Commentary.

This statement relies on solid scientific evidence showing that in specified situations, MNT has no beneficial impact on body composition, function, and well-being. Discounting MNT may lead to individual emotional and/or ethical conflicts according to different religious or cultural beliefs and views among patients, or their relatives. It could also cause conflicts within the NST/physicians and other health care professionals. These potential conflicts should be taken into account in the communication within the team and with the patient and their relatives to achieve consent.

Statement 22.

A medical treatment, which does not provide any benefit or when the potential disadvantages outweigh the expected benefits, has become disproportionate and can be withdrawn or withheld. Limitations of treatment may imply progressively withdrawing it or reducing the dose administered to limit side effects.

Strong consensus 91% agreement.

Commentary.

As stated above, MNT is a medical intervention that requires an indication for achieving a treatment goal and the informed consent of the competent patient. MNT is useful if it is given in order to improve the life expectancy and QOL of the patient.

MNT should not be confused with artificial hydration, which can be given to prevent or reverse discomfort due to dehydration. MNT can be withheld while hydration is continued.

4.1.2. Voluntary refusal of nutrition and fluids

Statement 23.

Voluntary cessation of nutrition and hydration is a legally and medically accepted decision by a competent patient. This option is particularly relevant in the context of advanced illness with a frustrating prognosis or during the final phase of life. This is facilitated by an advance directive.

Strong consensus 91% agreement.

Commentary.

It has been shown that competent patients sometimes voluntarily refuse nutrition and fluids to hasten death that is yet not imminent while they are receiving palliative care either at home or in hospice. The statement does not refer to patients with eating disorders. A competent patient in the context means cognitively intact and well-informed about the consequences of the decision.

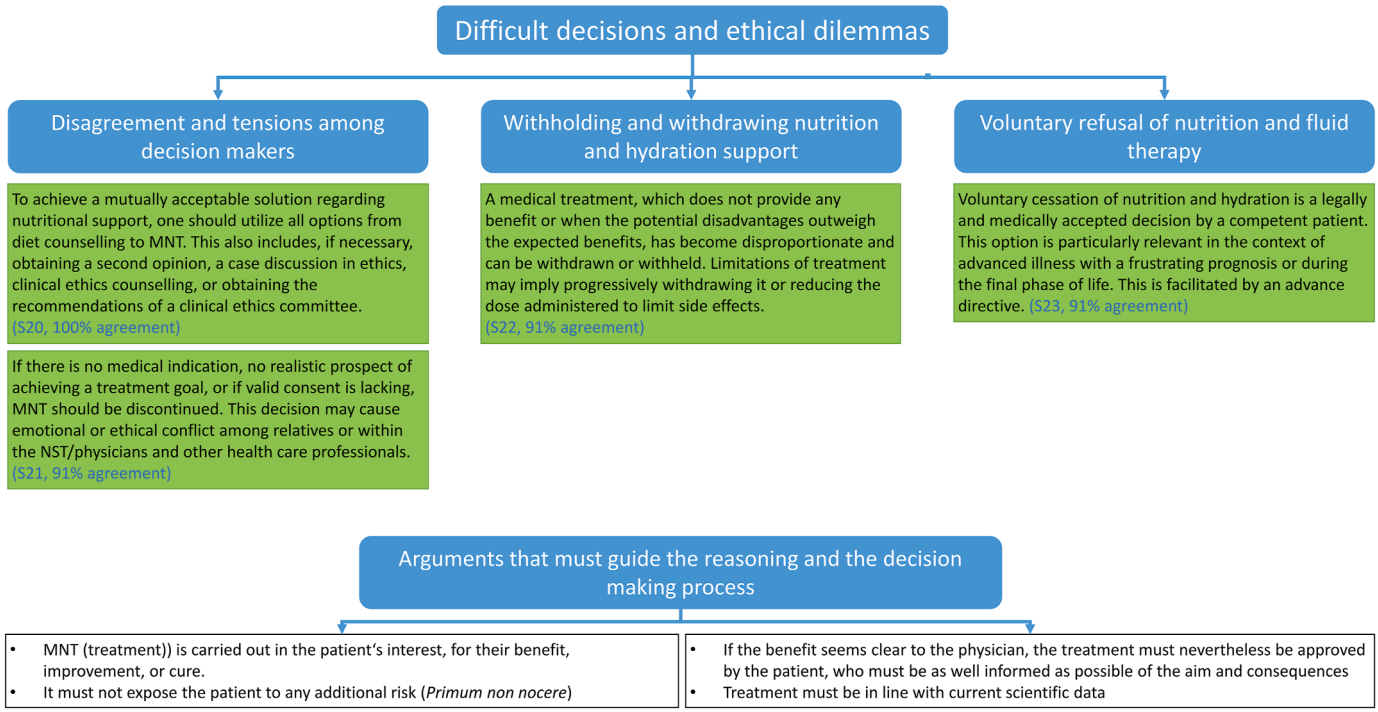

Fig. 4. Difficult decisions and ethical dilemmas. Abbreviations: MNT, medical nutrition therapy; NST, nutrition support team.

4.2. Special situations

MNT can be performed nowadays in different settings (e.g., in hospitals, nursing care, at home). The ethical challenges, however, do not differ principally depending on this setting. In the following sections, particular settings and conditions are discussed in more detail with regard to ethical aspects.

4.2.1. Old age

Statement 24.

MNT for older patients is frequently intended not merely as a temporary measure, but to ensure a permanent supply of nutrition and hydration up to the end of life. Therapy can be effective until the dying phase in cases of chronic disease. The justification for such a treatment should be critically reviewed at regular intervals.

Strong consensus 100% agreement.

Commentary.

MNT should be tailored to the needs of the older person, as they have an increased risk of malnutrition and dehydration. Impaired thirst sensation is one of the leading causes. Age, *per se*, is also a risk factor of malnutrition, and in addition, older persons typically suffer from multiple diseases (comorbidities) resulting in malnutrition [44]. Age-related alterations call for complex ethical decisions because of the wide range of medical options [45,46].

In many instances, older persons find it difficult to ingest food, and the diversity of their diet is reduced. The interventions aimed at providing sufficient food of adequate quality and quantity are of crucial importance for preserving health and QOL.

"Nutrition until the end of life" does not necessarily differ from nutrition in the acute medical setting. The goal of therapy and the indication for starting and concluding the therapy should be established here in the same manner while safeguarding the patient's self-determination.

Ethical dilemmas involving nutritional interventions in older persons can occur when the oral intake does not provide sufficient nutrients to prevent malnutrition. This occurrence also has significant psychological and social functions. Respecting the patient's preferences is a priority concerning the use of MNT when attempts at increasing the oral intake do not result in sufficient nutrient intake [47]. Nutritional and hydration care for older persons needs to be individualized and comprehensive to ensure adequate intake, maintain or improve nutritional status, and improve the clinical course and QOL. Older persons with a reasonable prognosis should be offered EN if the oral intake is not meeting their needs for more than three days or expected to be less than 50% of requirements for one week (Fig. 5).

Statement 25.

As long as no informed decision about MNT can be made, the same principle applies as in all cases in which the preservation of life reaches its limits: *in dubio pro vita* (when in doubt, favor life).

Strong consensus 100% agreement.

Commentary.

The application of this principle definitely encompasses the unconditional obligation to minimize or eliminate uncertainty as early as possible by initiating diagnostic measures and making all appropriate efforts to alleviate the situation [18].

Statement 26.

The voluntary renouncement of food and drink may be an expression of self-determined dying through an autonomous decision about one's own life. It must be clearly distinguished from a lack of appetite or reduced intake for other reasons, e. g. severe depression or disease-related causes.

Strong consensus 95% agreement.

Commentary.

It may be difficult to differentiate between a person's conscious and persistent relinquishment of the wish to live and a psychiatric or organic disease calling for treatment; this needs a thorough medical evaluation. In these complex cases, shared decision-making with the NST and in the absence of, physician and other (mental) health care professionals, relatives, and whenever possible, clinical ethics committee consults are recommended.

Fig. 5. Special situations. Abbreviations: EN, enteral nutrition; MNT, medical nutrition therapy; PN, parenteral nutrition; QOL, quality of life; VS/UWS, vegetative state/unresponsive wakefulness syndrome.

Provided no psychiatric disease is present or the psychiatric disease cannot be significantly improved by a therapy attempt, the tentative initiation or continuation of nutritional therapy must be adequately justified by the fact that it offers the patient realistic chances of improving their QOL. This has to be communicated extensively to the patient in order to obtain consent to the treatment [48].

4.2.2. Dementia

Statement 27.

The decision to discontinue MNT might be misunderstood as an order "do not feed" as nutrition is associated with life and its absence with starvation. For patients with eating difficulties requiring support**, an individual care plan has to be established. Such a feeding care plan should be called "comfort feeding" to avoid the negative connotation of the wording. Especially in regard to medical decisions at the end of life, appropriate terminology has to be carefully chosen.**

Strong consensus 93% agreement.

Commentary.

Advanced stages of dementia are often associated with reduced nutrient intake, which results in weight loss. In these situations, health care professionals and relatives are confronted with the decision regarding EN to provide adequate nourishment for these patients.

However, it also applies in this situation that MNT and hydration are medical interventions and not only a basic provision of food and fluids. Furthermore, the available evidence indicates that the long-term prognosis for patients with dementia remains unchanged, and there is no reduction in the risk of aspiration when they are provided with nutrition via tubes [47,48].

"Comfort feeding" is a term that avoids negative connotations and defines an individualized feeding care plan [49]. Words shape our thinking, and our thoughts lead our acts. Words like "stopping artificial nutrition" are perceived negatively and raise fear, although they may express evidence-based fact [18]. In addition, the approach may be different according to countries and cultures.

Dementia is accompanied by a variety of changes that result in an increased risk of malnutrition and low-intake dehydration [47]. Oral nutrition may be supported by eliminating potential causes of malnutrition and dehydration, with adequate social and bedside support and careful hand feedings. Oral nutritional supplements are recommended to improve nutritional status, but not to correct cognitive impairment or prevent cognitive decline. EN and/or PN are temporary options in patients with mild or moderate dementia, but not in severe dementia or in the terminal phase of life [47,50].

In all stages of the disease, supporting food and drink intake and maintaining or improving nutrition and hydration status requires an individualized, comprehensive approach. Due to a lack of appropriate studies, most recommendations are good practice points. Advanced dementia should be seen by the NST and, in the absence of, physician, and other health care professionals as an end-of-life phase, and they should clearly communicate this to the patient's relatives, significant others, caregivers, and/or surrogate decision makers. If oral intake is inadequate, any use of EN requires a thorough discussion of short-term and long-term benefits versus burdens/risks. The decision to withhold or withdraw EN in end-stage illness is supported by current scientific evidence. The autonomy of the patient or surrogate decision maker should be respected. Emphasis should be placed on functional status and QOL [51]. In 2010, "comfort feeding" only (CFO) was introduced as an alternative to EN, which has been appropriate for many patients with advanced dementia. However, a new concept to consider is "minimal comfort feeding" (MCF), where caregivers provide nutrition and hydration only in response to the patient's signs of hunger and thirst, rather than offering food and liquids proactively as with CFO. MCF may better accommodate the preferences of those individuals with advanced dementia. Advance directives that designate to stop all nutrition and hydration when the individual reaches advanced dementia may not have been taken into consideration addressing physical discomfort [47,51,52].

Statement 28.

For patients with advanced dementia, preference should always be given to careful eating assistance (feeding by hand) and comfort feeding.

Consensus 86% agreement.

Commentary.

Patients with dementia may have an acceptable risk/benefit ratio when requiring EN only for a short time in the context of disease-directed treatment and with the (potential) goal of returning to oral intake. As long as patients with dementia have decisional capacity, they have to be included in the communication [49,51,53].

4.2.3. Persistent vegetative state (VS)/unresponsive wakefulness syndrome (UWS)

Statement 29.

Ethical dilemma prevention and resolution involving patients in a VS/UWS requires establishing an exact diagnosis, anticipated trajectory of the condition, treatment goals and plans, and shared and empathic communication about medical treatments between the clinician and the patient's relatives. If indicated and without clear advance directives, nutritional therapy and hydration should be given in any case of uncertain prognosis.

Strong consensus 91% agreement.

Statement 30.

Once the diagnosis of persistent VS/UWS is established, an advance directive or the presumed wish of the patient has to be considered. If there is evidence that is applicable to the given case, it has to be followed.

Strong consensus 93% agreement.

Commentary.

Persistent VS/UWS syndrome is defined as an unconscious state after severe brain injury that lasts longer than a few weeks [54]. Terms and legal implications vary in the different countries. There is a broad ongoing discussion about the accuracy of diagnosis, the potential for recovery, and the extent of care such patients should receive, which exceeds by far the scope of this document. After one year of posttraumatic persistent VS, recovery is extremely unlikely. For non-traumatic persistent VS, chances of recovery after three months are exceedingly rare [54].

Diagnosis of disorders of consciousness pertains to patients in the following categories: coma; VS, also known as UWS; minimally conscious state; and locked-in syndrome [55]. Patients in a VS/UWS pose ethical dilemmas, including the use of MNT, with possible conflicts occurring between health care professionals and relatives of these patients. Several key factors have been identified to prevent or solve these conflicts. The importance of establishing a diagnosis, consistency in treatment goals and plans, open and empathic communication, expertise, and understanding the importance of opposing feelings/thoughts. Shared compassion for the patient, gaining trust of the relatives, and working towards shared decision making for medical decisions are key in conflict prevention and resolution [39,55].

Several cases of patients with persistent VS/UWS have received worldwide attention from the media. In all these cases, the question of dispute was a potential withdrawal or continuation of MNT. For those patients, feeding by the oral route is not an option, so the withdrawal of MNT would lead to their death. The presence of a potentially achievable and beneficial treatment goal is a prerequisite for patients in a persistent VS/UWS, in addition to their presumed or expressed wishes.

4.2.4. Palliative care

Statement 31.

MNT has become a part of palliative care, e.g., in neurological and cancer patients, with the potential to increase survival and QOL in selected patients. Long-term home EN and PN programs should be considered (for details, see disease-related guidelines).

Strong consensus 97% agreement.

Commentary.

The WHO defines palliative care as an approach that improves the QOL of patients and their relatives facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other physical, psychosocial, and spiritual problems. Palliative care is a life-affirming approach that views dying as a normal process that, while it should not be accelerated, ought not to be impeded or prolonged either. The aim is to foster and sustain an optimal QOL until death.

PN has become an integral part of palliative care in cancer, mainly, allowing increased survival in terminal cases without gastrointestinal access, and who would have died from starvation

and not primarily from their malignant disease. Long-term home PN programs include these patients with reasonable results [56,57]. However, good evidence should support the use of MNT for each disease that may trigger the need for palliative care [56,58].

Palliative and hospice care both focus on QOL for individuals with a serious illness, with an emphasis on comfort and pain relief. Both involve an interdisciplinary health care approach to meet the patient's individual needs. In palliative care, clinicians focus on helping patients understand their medical treatment options, especially in complex cases, and include physical, emotional, spiritual, and psychosocial support, incorporating a patient-centered approach [23]. Hospice care is provided for a person in the end-of-life phase, and a cure for the illness is not possible [59]. Inadequate oral intake, weight loss, malnutrition, muscle protein depletion, metabolic derangements, and fatigue can occur with advanced cancer, severely impacting the individual's QOL, physical function, and treatment tolerance. Yet use of MNT is associated with burdens and risks that need to be weighed against the expected benefits, with the understanding, from the perspective of the patient [60], and consent of the patient. The goal of the 2017 ESPEN guidelines on nutrition in cancer patients identified recommendations for NSTs responsible for the identification, prevention, and treatment of reversible elements of malnutrition in cancer patients [61]. Decisions on nutrition interventions must consider social, cultural, emotional, spiritual, and ethnic backgrounds. Patients with cancer in palliative care receiving MNT may be more likely to contribute to improving the person's QOL when provided as part of a comprehensive early palliative care approach [62]. The decisions to provide MNT for patients in palliative or hospice programs involve physiological outcomes and interpersonal influences that should be considered. The approach to end-of-life nutrition care comprises the intersection of the medical condition, patient/provider beliefs, and geographic and cultural influences [63]. For patients in hospice, support with any treatment choices should incorporate the patients' preferences, taking into consideration emotional and rational aspects in decision-making of MNT, and emphasize the need for health care providers to recognize individual, medical, and social factors [57,58,61,64,65] (Fig. 6).

Statement 32.

All patients and their relatives (if the patient consents) shall be engaged in person-centered dialogue, to the extent possible in individual cases.

Strong consensus 91% agreement.

Commentary.

It is essential to actively involve the patient and their relatives in the plan for the nutritional care in accordance with the principles of person-centered care [66]. Communicating in close dialogue with the patient and the relatives in the treatment process regarding the planning and setting of goals, ultimately promoting well-being, involvement, and participation, is of great importance. Person-centered care emphasizes a partnership between patients and health care professionals and is advocated by the WHO as a key component of quality health care [65,67].

Statement 33.

Nutrition is an integral part of palliative care and should be offered according to the different stages in the palliative journey, from active treatment to the end-of-life stages.

Strong consensus 96% agreement.

Commentary.

Palliative care involves a structured and goal-oriented approach with a holistic view of the patient. It affirms life and acknowledges death as a normal process. According to the WHO's definition of palliative care, the goal of nutritional therapy is to achieve the best possible QOL, encompassing functional, psychological, and social well-being [68]. Care spans an early phase, which may be prolonged, and a later phase, which may be brief (end-of-life care), lasting a few days or weeks. In the early stage, the objective is to provide the best possible QOL, aiming to meet energy and nutritional needs to the greatest extent possible and to alleviate nutrition-related symptoms such as swallowing difficulties, nausea, and early satiety as important parts of nutrition care. For those unable to sustain themselves solely through regular food intake, the prescription of MNT may be particularly relevant.

In a later stage, when the patient approaches the end-of-life phase, the conditions for energy and nutrient intake gradually change, and the focus shifts solely to ensuring the best possible QOL and adapting care according to individual preferences. As part of the natural dying process, the body loses the ability to metabolize nutrients. There is a gradual decline in dietary intake until it ultimately ceases entirely [47]. Nevertheless, this reduction in intake does not necessarily cause discomfort such as hunger or thirst [69]. In this phase, comfort-feeding served through hand-feeding tailored to individual preferences and capabilities is recommended [47].

Statement 34.

The palliative approach must include support **and education for the relatives (if a competent patient consents) in order to function effectively.**

Consensus 80% agreement.

Commentary.

It is essential to give the relatives time to understand and come to terms with the situation. Therefore, a continuous dialogue during the entire palliative care process is essential. Especially during the end-of-life phase, communication with the relatives is vital to clarify the objectives of ongoing care, including which nutritional interventions, if any, may be appropriate. Given that food and nutrition are seen as symbols of caring for life, the way health care staff approach this issue is of great importance, particularly in addressing the concerns of relatives who may struggle with the decreasing relevance of food and drink. Requests for MNT may arise sometimes as a query, but at times more insistently. This is likely an expression of concern and care. Thus, it is crucial to take the time and patiently explain that the dying person has reached a point where food and nutrition no longer play a role in survival or well-being. On the contrary, such interventions may cause harm and exacerbate suffering. More than one conversation may be necessary. Those close to the patient must be given the opportunity to ask questions and express their concerns. Information may also need to be repeated, as the loss of a parent, partner, or close friend can be profound and difficult to accept. Individuals may react very differently. Some may appear aggressive or highly critical of the care being provided, which is an expression of the intense emotions they are grappling with.

4.2.5. The dying patient (end-of-life phase)

Statement 35.

There are no clear criteria to ascertain the beginning of the dying phase. Therefore, a nutritional intervention in this phase of life should be followed in an individualized manner after consultation with the patient.

Strong consensus 100% agreement.

Commentary.

The end of a person's life is a process, which is expandable *per se*, at a certain point, deterioration is accelerated. This period may be prolonged by nutritional support if people are predominantly starving, and when a gain or preservation of QOL is possible. If this is not possible, the intention of this treatment in dying persons is to satisfy hunger and thirst [70]. An individual's expressed wishes and needs may change in the final phase of their life. In fact, each person

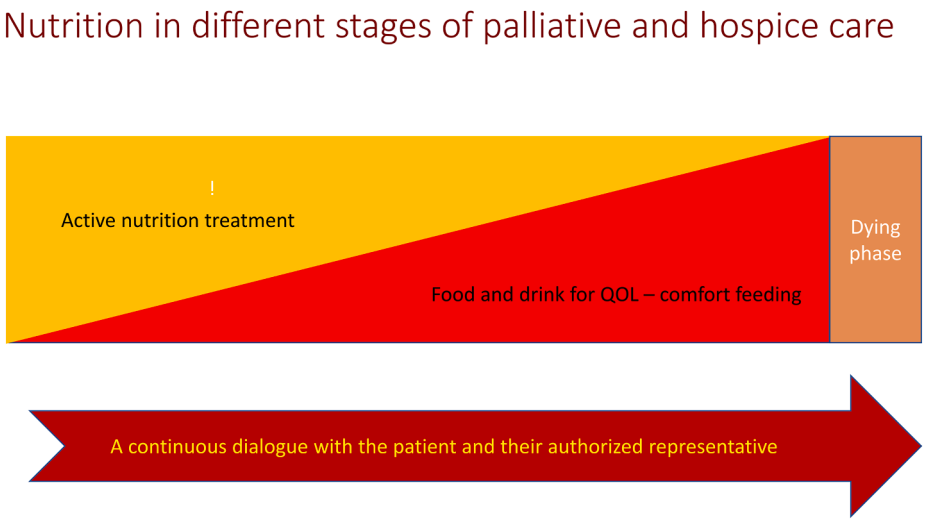

Fig. 6. Nutrition in different stages of palliative and hospice care. Abbreviation: QOL, quality of life.

demonstrates a different type of behavior until the time of death. The indication for MNT should therefore be established at this time after careful and individualized consideration of the potential risks and benefits with the purpose of providing end-of-life care [3,47].

Administration of fluid and energy is not always needed at all times in this phase of life. Patients do frequently experience dryness of the mouth, an early sensation of satiety, nausea, and an impaired sense of taste, but rarely hunger and thirst. The sensation of thirst generally results from unpleasant dryness of the oral cavity and crust formation and can be frequently relieved by oral care and small quantities of fluids, less than necessary to relieve dehydration. The patient, if able, may request food products/liquids that have no nutritional value but bring them comfort. Parenteral administration of fluid does not necessarily alleviate the individual's thirst. Furthermore, this may result in fluid overload, increased pulmonary secretions, incontinence, and skin breakdown/pressure sores [71,72].

4.2.6. Nursing care

Statement 36.

MNT shall never be used for the purpose of reducing the workload and effort of the nurses and caregivers.

Strong consensus 91% agreement.

Commentary.

Especially, EN should be evaluated very carefully. Even in cases of an indwelling percutaneous endoscopic gastrostomy, all options of natural food intake should have been exhausted (the pleasure of eating, the attention of nursing personnel, practicing the intake of food) [73–76]. In persons with dementia or those with severe cerebral damage, a feeding tube may still be used as a legitimate nursing aid in specific situations [77–80]. Tube feeding may save time and effort and reduce nursing staff concern about fluid and calorie intake. However, it should only be used after all natural feeding options are exhausted, when there is a clear medical indication and treatment goal, when it is supportive rather than substitutive, when it offers foreseeable benefit through time gained for care for the patient themselves, and when it enables care in the home environment.

4.2.7. Intensive care unit (ICU)

Statement 37.

MNT and hydration are standard therapies in critically ill patients. However, in this and other clinical settings, if no treatment goal remains and the interventions are no longer medically indicated (i.e., futile), they must be withheld or withdrawn.

Strong consensus 91% agreement.

Commentary.

Withholding or withdrawing a treatment that provides no benefit or has become disproportionate is, from an ethical and a legal point of view, the same. However, it is to be emphasized that if a therapy is being stopped, standard care or palliative care comfort still has to be provided to the patient. This implies that even when MNT and hydration are stopped, standard care to maintain a good QOL for the patient has to be maintained [81].

Even though often practiced in daily work, hydration and MNT should not necessarily be continued in ICU patients in the dying phase. Nevertheless, there is still ongoing controversy and discordant beliefs in practice regarding when to terminate MNT and hydration. This is due to the fact that there is more additional emotional value attached to the provision of nutrition and hydration than, for instance, continuing antibiotics or other treatments, even though MNT and hydration can have adverse effects such as catheter complications and infections. In addition, hydration may even prolong and aggravate the dying phase [82].

4.2.8. Forced feeding (this chapter does not discuss patients suffering from anorexia nervosa)

Statement 38.

Providing nutrition against the wish of a patient who is capable of giving informed consent or making decisions (i.e., forced feeding) is generally prohibited.

Strong consensus 100% agreement.

Commentary.

Although the legal situation might differ in some countries, the World Medical Association has established clear guidelines for physicians involved in managing people on hunger strike. According to the World Medical Association Declaration of Tokyo, the forced feeding of hunger strikers who are mentally competent is not allowed. “Hunger strikers should not be forcibly given treatment they refuse. Forced feeding, contrary to an informed and voluntary refusal, is unjustifiable. Artificial feeding with the hunger striker's explicit or implied consent is ethically acceptable” [83,84].

5. Human rights in clinical nutrition

Statement 39.

The topic of MNT administration is covered by the right to life according to Article 2 European Convention on Human Rights (ECHR, 1950), which imposes a duty of protection on the

state. Therefore, the state is obliged to issue legal regulations (i.e., in this case, for medicine). However, a specific level of medical care cannot be constitutionally determined. The access to nutritional care as a process is a human right, as agreed in the 2022 Vienna Declaration.

Strong consensus 91% agreement.

Commentary.

MNT is a medical therapy requiring an indication, a reachable therapeutic goal, and the consent of the patient. It is far too special to be an "independent human right," as there also is no "human right" to obtain a certain medication when suffering from a disease. A specific therapy can never fall into the category of human rights. At any rate, it is part of good clinical practice. However, it is possible to promote access to nutritional care based on the human rights-based approach [4,85]. This should not imply the obligation to feed the patients under any circumstances or at any stage of life. Patients or health care professionals cannot claim "the right to food" to prolong feeding if MNT is not indicated, futile, or it may cause harm. This right implies, from an ethical point of view, that the best decision for the patient must be taken, and this may include, under certain circumstances, the decision not to feed [13].

In 2022, Clinical nutrition societies signed the "International Declaration on the human right [18] to nutritional care" during the ESPEN congress in Vienna. In this declaration, 75 Clinical Nutrition societies recognized that the human rights-based approach can be a tool to promote access to nutritional care, and to raise awareness and the development of policy and programs in clinical nutrition [4,86] (Fig. 7).

6. Culture and religion

Statement 40.

There should be awareness and obligatory education for medical personnel to enable them to treat patients appropriately to their spiritual needs. Respect for the religious, ethnic, and cultural background of patients and their relatives has to be granted.

Consensus 88% agreement.

Commentary.

We live in increasingly multicultural societies and are confronted with the various beliefs and attitudes regarding the body and human life originating in different cultures and religions. Therefore, respect for the religious, ethnic, and cultural background of patients and their relatives has to be granted [87]. If information about the specific preferences cannot be obtained, a conservative approach is recommended [18,88] (Fig. 7).

7. Conclusion

MNT is a medical intervention which requires an indication, an achievable treatment goal and the consent of the patient. It is imperative that the reasoning and the course of action in clinical nutrition are presented in accordance with this ethical framework, for which ethical principles must be considered. Likewise, whenever the health care professional's beliefs and attitudes are in conflict with the patients' wishes, an orderly transfer of care should be initiated.

Declarations

This guideline has been developed with reasonable care and with the best of knowledge available to the authors at the time of preparation. They are intended to assist health care professionals and allied health care professionals as an educational tool to provide information that may support them in providing care to patients. Patients or other community members using this guideline shall do so only after consultation with a health professional and shall not mistake this guideline as professional medical advice. This guideline must not substitute seeking professional medical and health advice from a health professional.

Author contributions

Conceptualization: Diana Cardenas, Rosa Burgos, Elisabet Rothenberg, and Arved Weimann; Data curation: N/A for a guideline: Formal analysis: N/A for this guideline; Funding acquisition: No separate funding, the guideline was supported by ESPEN; Investigation: N/A for a guideline; Methodology: Arved Weimann; Project administration: Diana Cardenas, and Arved Weimann; Resources: N/A for a guideline; Software: N/A for a guideline; Supervision as Guideline Officer: Arved Weimann; Validation: All authors; Visualisation: Diana Cardenas, Rosa Burgos, and Elisabet Rothenberg; Writing – original draft: Diana Cardenas, Rosa Burgos, Elisabet Rothenberg, and Arved Weimann, for the underlying Guideline version of 2016 Christiane Druml; Writing – review and editing: All authors; Final approval: All authors.

No one eligible for authorship has been excluded from the list of authors.

Data sharing statement

N/a for guidelines.

Ethical approval

Not necessary.

Generative artificial intelligence and AI-assisted technologies in the writing process

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Conflict of interest

The expert members of the working group were accredited by the ESPEN Guidelines Group, the ESPEN Education and Clinical Practice Committee, and the ESPEN executive. All expert members have declared their individual conflicts of interest according to the rules of the International Committee of Medical Journal Editors (ICMJE). If potential conflicts were indicated, they were reviewed by the ESPEN guideline officers and, in cases of doubts, by the ESPEN executive.

DC: honoraria for lectures from Fresenius Kabi, Nutricia, Nestlé Health Sciences, and ASDIA, Ethics Editor of Clinical Nutrition, Associate Editor of Clinical Nutrition; RB: nothing to declare; ER: payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events from Pfizer; PB: nothing to declare; AB: ASPEN Board of advisors; ASPEN-Rhoads Research Foundation Board of Directors; Editorial Board- Nutrition in Clinical Practice; SCB: grants for conduction of clinical trials from Heilerde-Gesellschaft Luvos Just GmbH & Co. KG, Symbiopharm GmbH, and Lactopia GmbH, payment or honoraria for lectures etc. from Falk Foundation, Elly Lilly, German Society for Probiotic Medicine e. V. (DeProm), Takeda Pharma Vertrieb GmbH & Co. KG, and Janssen-Cilag GmbH, participation on a Data, Safety Monitoring Board or Advisory Board of Nestlé Health Science and

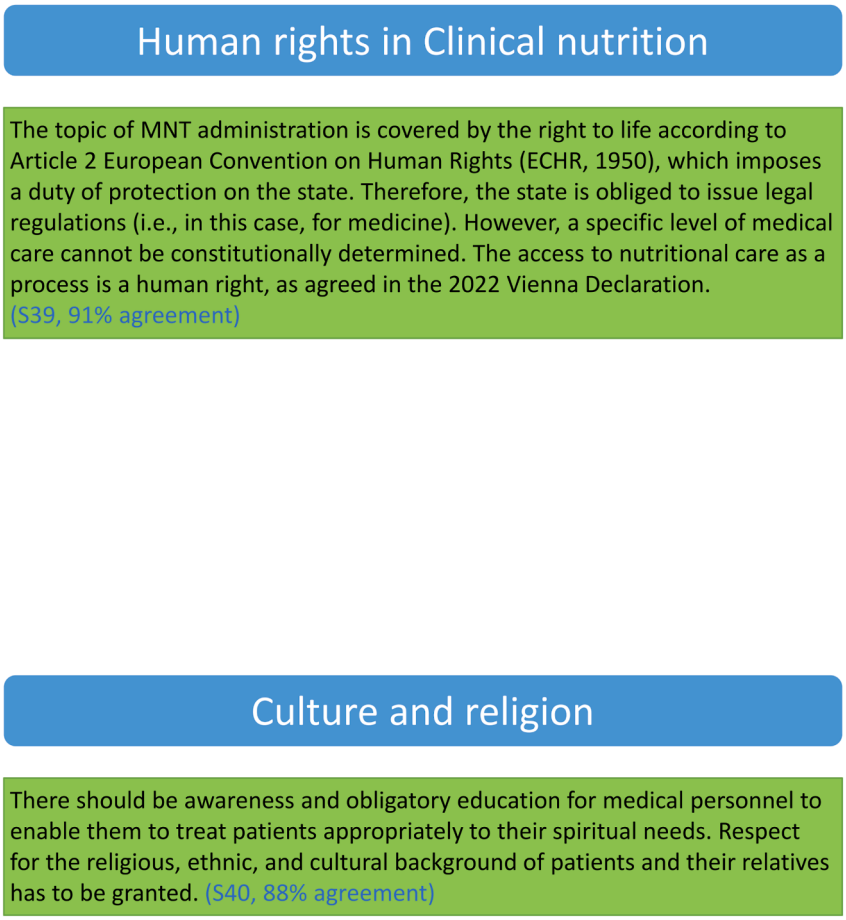

Fig. 7. Human rights in Clinical Nutrition as well as Culture and religion. Abbreviations: MNT, medical nutrition therapy.

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Appendix A

Ethical background of the working group members.
Sorted alphabetically by last name.

Peter Ballmer:	Initiator of the Commission for Medical Ethics in role as Director, Department of Internal Medicine, Kantonsspital Winterthur, Switzerland
Albert Barrocas:	Board Certified General Surgeon with 50+ years experience in nutrition support. 40+ years dealing with end-of-life care and bioethics. Multiple presentations and publications on the subject. Member and Chair of several ethics committees. Highlighted the codundrum of what Can be done technologically, what Should be done ethically, and what must be done legally, and dubbed it the Troubling Trichotomy(T3). More recently proposed the concept of the ethical Biopsy as a template for ethical decision making
Stephan C. Bischoff:	Clinician with years of experience in clinical nutrition
Rosa Burgos:	Chair of the healthcare ethics Committee at Vall d'Hebron hospital in Barcelona, Spain, Professor of Bioethics at the Faculty of medicine, autonomous University of Barcelona
Diana Cardenas:	Clinical nutritionist and PhD on philosophy. She is the head of the ethics committee of the French Speaking Society (SFNCM). She is member of the ethics committee at Institut Gustave Roussy, France, and the coordinator of the International working group for the patient's right to nutritional care.
Cristina Cuerda:	Clinician with years of experience in clinical nutrition
Christiane Druml:	Holder of the UNESCO Chair on Bioethics at the medical University of Vienna; President of the Austrian Bioethics Committee, Austrian Federal Chancellery, Vienna; Former member of the International Bioethics Committee (IBC) of UNESCO (2008–2016)
Laurence Genton:	Clinician with years of experience in clinical nutrition
Kathleen Gura:	Clinical nutrition support pharmacist
Michael Hiesmayr:	Anesthesiologist and Intensive Care physician, former Head of the Division of Cardiac Thoracic and Vascular Anesthesiology and Intensive Care, member of the ethical Committee of the medical University Vienna 2002–2025, Delegate of the medical University Vienna to the national nutrition Commission of the Austrian Ministry of health 2011–2016.
Ajay Kumar Jain:	Clinician with years of experience in clinical nutrition
Stanislaw Klek:	Member of the ethics Committee of the national Cancer Institute in Krakow
Florian Poullenot:	Gastroenterologist specialized in home parenteral nutrition. President of the Clinical ethics Committee of the French Society for Clinical nutrition and Metabolism (SFNCM). PhD student in philosophy (ethics of care).
Elisabet Rothenberg:	
Stéphane Schneider:	Clinician with years of experience in clinical nutrition
Denise Baird Schwartz:	Bioethics Committee member at Providence Saint Joseph medical Center for 20 years (10 years as the Community member additionally serving on Surrogate Committees representing patients who lack decision-making capacity and do not have a family member or designated decision maker)
Pierre Singer:	Past vice Chairman of the Israel medical Association ethics Board, past member of the ethics committee of the Beilinson hospital, Rabin medical Center, Petah Tikva, Israel
Mehmet Uyar:	Past member of Institutional ethics Committee of Ege University hospital, Izmir, Turkey
Arved Weimann:	M.A. Medical ethics, Chairman of the ethics Committee St. George hospital, Leipzig, Germany, member of the working group procedural transplantation ethics of the German medical Association
Miriam van der Werf:	ESPEN early Career faculty member, registered dietician, and senior lecturer specialized in clinical nutrition therapy

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