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REVIEW ARTICLE

To feed or to care? Nutritional support in palliative care from a personalist bioethics perspective

¿Alimentar o cuidar? La atención nutricional en cuidados paliativos desde la bioética personalista

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Abstract

In the context of palliative care, nutritional decisions involve the challenge of assessing the therapeutic proportionality of nutritional interventions, discerning when nutrition constitutes an act of care consistent with respect for the person's dignity and quality of life, and when its implementation or withdrawal may result in interventions that are disproportionate to the expected benefits. This article reflects on the role of nutrition in palliative care from the perspective of personalist bioethics, which recognizes the inherent dignity of the person and prioritizes the integral care of human life. It also examines the professional responsibility of the nutrition professional in decision-making processes oriented toward quality of life, respect for patient autonomy, and empathetic communication with patients and their families. Finally, the article proposes ethical guidelines to promote a humanized nutritional practice consistent with the principles of therapeutic proportionality, beneficence, and respect for human dignity.

Keywords: Bioethics; Palliative care; Dignity; Nutrition.

Resumen

En el contexto de los cuidados paliativos, las decisiones nutricionales plantean el desafío de valorar la proporcionalidad terapéutica de la alimentación y discernir cuándo esta representa un acto de cuidado coherente con la dignidad y la calidad de vida de la persona, y cuándo su utilización o suspensión puede derivar en intervenciones desproporcionadas respecto de los beneficios esperados. Este artículo analiza el papel de la nutrición en los cuidados paliativos desde la perspectiva de la bioética personalista, la cual reconoce la dignidad de la persona y prioriza el cuidado integral de la vida humana. Asimismo, se reflexiona sobre la responsabilidad del profesional de la nutrición en la toma de decisiones orientadas a la calidad de vida, el respeto de la libertad y la comunicación empática con el paciente y su familia. Finalmente, se proponen lineamientos éticos que promueven una práctica nutricional humanizada, coherente con los principios de proporcionalidad terapéutica, beneficencia y respeto por la dignidad humana.

Palabras clave: Bioética; Cuidados paliativos; Dignidad; Nutrición.

Introduction

Palliative care constitutes a comprehensive approach to the care of individuals living with advanced, progressive, and incurable illness, aiming to improve the quality of life for both patients and their families (Holdoway, 2022). According to the Organización Mundial de la Salud [World Health Organization - WHO], the aim of palliative care is to prevent and alleviate suffering through early identification, comprehensive assessment, and appropriate management of pain and other physical, psychological, social, and spiritual issues (Bozzetti, 2020). This care model recognizes inherent human dignity and identifies the patient at the center of the therapeutic process, prioritizing the relief of suffering over the prolonging survival or early death (Koithan & Taylor-Swanson, 2025).

Within this framework, nutritional care represents an essential component of palliative care (Bozzetti, 2020). Beyond its biological function, food is a profoundly human act that carries emotional, cultural, and symbolic meaning (Holdoway, 2022). In patients with advanced conditions, including terminal cancer, neurodegenerative diseases, chronic organ failure, as well as frail older adults with severe dependency or those who are bedridden, nutritional management presents unique clinical and ethical challenges (Bozzetti, 2020). Loss of appetite, cachexia, dysphagia, fatigue, and the progressive decline of physiological functions frequently impair both food intake and nutrient utilization, giving rise to complex clinical and ethical dilemmas (Clark & Batten, 2024).

Healthcare professionals and family members are often confronted with difficult decisions regarding the initiation, continuation, or withdrawal of nutritional interventions, including artificial nutrition and hydration (Clark & Batten, 2024). These situations raise a fundamental ethical question: when does nutritional support become an expression of therapeutic obstinacy rather than an act of care? The line between compassionate support, the disproportionate prolongation of the dying process, and the unjustified omission of basic care is frequently difficult to define. From an ethical perspective, it is necessary to reflect on the limits of nutritional intervention in people receiving palliative care.

When the withdrawal of nutrition and hydration is not supported by rigorous clinical assessment or by ethically proportionate decision-making, it may constitute a form of therapeutic abandonment (Clark & Batten, 2024). Distinguishing between allowing the natural death and accelerating it through the omission of basic care requires prudent reflection, basis of respect for the person, an objective assessment of clinical benefit, and a commitment to relief of suffering. In this sense, the determination of quality of life becomes a central yet complex element, as it is shaped by subjective, cultural, and relational dimensions that transcend biomedical indicators.

Personalist bioethics offers a solid theoretical framework for addressing these dilemmas by recognizing the human person as the foundation of clinical decision-making (Fayos, 2014). From this perspective, nutritional care in palliative settings should be guided by the principle of therapeutic proportionality, which requires considering the patient as an integral unity of biological, psychological, and spiritual dimensions (de la Garza & Zonenszain-Laiter, 2022). Likewise, the principle of responsibility calls for a careful evaluation of the consequences of healthcare professionals' decisions, acknowledging their ethical commitment to the patient's well-being (de Siqueira, 2001). In addition, the principle of freedom recognizes the patient's right to participate actively in decisions regarding their own care, with respect for their autonomy, values, and life project, even in the context of advanced illness. Finally, the principle of precaution requires healthcare professionals to act prudently when considering interventions that may pose greater risks than benefits, especially when scientific evidence is limited or when the risks outweigh the potential benefits (de La Garza & Zonenszain-Laiter, 2023).

In this context, the role of dietitians and nutritionists transcends the technical prescription of diets, evolving into that of professionals who support, guide, and humanize the

care process for patients with advanced illnesses. Their intervention requires not only professional competence but also a solid foundation in bioethics that enables them to discern when nutritional support constitutes an act of care and when it may instead represent a source of unnecessary suffering. This reflective article aims to analyze the principles of personalist bioethics in relation to the nutritional care of individuals with advanced illness, providing ethical insights that strengthen the practice of nutrition professionals in palliative care.

Nutrition and quality of life in palliative care

Nutrition is a scientific discipline concerned with the study of the processes through which the body obtains, transforms, and uses the Clinical nutrition is not limited to the provision of food; rather, it constitutes a therapeutic intervention aimed at preserving functionality, preventing complications, and promoting the overall well-being of the person (Cederholm et al., 2017).

On the other hand, quality of life is defined as a multidimensional concept that integrates the individual's subjective perception of their physical, emotional, social, spiritual, and functional state in relation to their expectations, values and cultural context (Shippee et al., 2017). Regarding health sciences, this concept takes on special relevance when considers not only survival, but also the comfort, autonomy, dignity, and life satisfaction experienced by the patient throughout the course of illness.

Terminal illness is characterized by a limited prognosis and a reduced life expectancy, generally under six months in the absence of effective curative treatment (Araújo et al., 2025). This phase is characterized by progressive functional decline, the presence of multiple and complex symptoms, increasing dependence on the care of others, and a diminishing response to conventional therapeutic interventions (Araújo et al., 2025). Therefore, the principal aim of healthcare is to prevent and relieve of suffering and the person well-being.

Suffering affects a person across biological, psychological, and spiritual dimensions, compromising their well-being and quality of life (Cassell, 2010). Factors that can influence the perception of suffering include physical and emotional pain, loss of autonomy, and increased functional dependence. In addition, stress, emotional state, and the quality of communication among the patient, the family, and the healthcare team play an important role in how suffering is experienced (de Antueno & Silberberg, 2018).

In this context, nutrition emerges as a key element of comprehensive clinical care, particularly for patients with a terminal illness. Nutritional status directly influences treatment tolerance, immune response, muscle strength, functional capacity, and subjective well-being (Cederholm et al., 2017). According to Druml et al. (2016), malnutrition, common in advanced illness, is associated with increased fatigue and susceptibility to infections, physical decline, and a lower quality of life. In patients with advanced cancer, cachexia, anorexia, and metabolic disturbances severely compromise nutrient intake and utilization. In these conditions, the authors suggest that the primarily aim of nutritional intervention is to maintain well-being, reduce symptoms associated with eating, and provide respectful support throughout the course of the illness. Similarly, in patients with neurodegenerative diseases such as amyotrophic lateral sclerosis or advanced dementia, dysphagia and the loss of autonomy present significant clinical and ethical challenges.

Adjusting food texture, providing feeding support, and, in some cases, considering artificial nutrition, should be evaluated based on the prognosis, patient's values, and the actual impact on quality of life. In frail older adults and bedridden patients with multiple comorbidities, nutrition plays a fundamental role in preventing pressure ulcers, maintaining muscle mass, and preserving residual functional ability. Nonetheless, during the end-of-life stage, the natural decline in appetite and energy requirements are part of

the biological decline, requiring careful interpretation by the healthcare team (Druml et al., 2016).

A study by Shippee et al. (2017) demonstrated that an intervention based on the Life Course methodology, designed to provide continuous, cross-cutting support, improved patient´s quality of life. In this study, quality of life was assessed at baseline and at six months using a functional tool for chronic disease management. On the other hand, Kavalieratos et al. (2016) conducted a meta-analysis to determine the association between palliative care and quality of life, symptoms, survival, and caregivers' quality of life. The authors concluded that palliative care showed some efficacy in improving, at least in the short term, quality of life and symptom burden in individuals with advanced illness.

Regarding palliative care, nutritional support transcends its purely biological dimension and acquires profound relational and symbolic significance. Sharing food, respecting patient preferences, and fostering pleasant experiences associated with eating contribute to emotional well-being and the strengthening of family bonds, even when dietary intake is limited (Stoian et al., 2025). In this context, artificial nutrition, defined as the supply of nutrients through alternatives to oral feeding when it is insufficient or impossible, becomes relevant (Druml et al., 2016).

Artificial nutrition includes enteral nutrition, which consists of administering nutrients directly into the gastrointestinal tract via tubes or specialized devices, and parenteral nutrition, which involves the intravenous administration of nutrients, through central or peripheral venous access (Cederholm et al., 2017). Enteral nutrition is considered the preferred route when the digestive system retains a minimal degree of functionality, due to its physiological similarity to natural feeding and the lower risk of metabolic complications.

Parenteral nutrition is reserved for situations where the gastrointestinal tract cannot be used safely or effectively, such as intestinal obstruction, prolonged paralytic ileus, or severe malabsorption (Druml et al., 2016). In individuals with advanced illness, the use of artificial nutrition presents specific clinical and ethical challenges. While these interventions can help maintain nutritional status during specific phases of the disease, their use must be carefully evaluated, taking into account prognosis, symptom burden, impact on quality of life, and patient preferences. From a palliative care perspective, the ethical value of enteral and parenteral nutrition is basis in the ability to minimize suffering.

Therefore, nutrition for individuals with advanced disease must be understood as an intervention focused on care, accompaniment, and respect for the person. Furthermore, it also focuses on alleviation of suffering, promote well-being, and preserve human dignity.

Personalist bioethics and the human dignity

Ethical consideration regarding nutrition and palliative care requires a solid anthropological basis that allows the patient to be recognized not only as the subject of a clinical intervention, but as a person with inherent dignity. In this context, personalist bioethics offers a theoretical and practical framework oriented toward to consider the human person at the center of every healthcare decision, recognizing their unconditional value regardless of functional status, prognosis, or degree of dependency.

In this context, Spaemann (1997) takes up Boethius's classic definition of the person as an "individual substance of a rational nature" and argues from it that human dignity is basis in the person's being, not in their qualities, capacities, or circumstances. What this definition, developed within personalist bioethics, lets us see is that a person possesses an intrinsic value and a permanent ontological identity, which does not depend on accidental characteristics such as autonomy, productivity, or present awareness.

Spaemann establishes that this intrinsic value is neither conferred nor lost; rather, it is inherent to human nature and endures throughout all stages of life. Consequently, human dignity is maintained across the whole life cycle, even in advanced disease, cognitive decline, or the end-of-life stage,

Spaemann (1997) emphasizes that human beings are not persons because they possess specific functions, but rather because they belong to a species whose identity is personal. In this regard, the author maintains that the notion of human nature is fundamental to this approach, since it cannot be reduced to a biological condition; on the contrary, it represents the intrinsic principle that guides human beings toward their fulfillment in the biological, psychological, and spiritual dimensions. Recognizing this constitutive reality implies, therefore, accepting that the person possesses a distinct ontological structure, open to relationship, meaning, and transcendence, whose unity must be preserved in order to respect their integrity. From this perspective, terminal illness does not diminish the intrinsic value of any human being; on the contrary, it highlights their vulnerability and their need for care, companionship, and recognition.

In the context of nutritional care, this approach prevents feeding –oral or artificial– as a technical procedure and instead situates it within a therapeutic relationship oriented toward the patient's well-being. Various studies in bioethics applied to nutrition have highlighted the risk of adopting reductionist approaches that focus on biomedical parameters or the efficiency of interventions at the expense of a holistic understanding of the person (de la Garza & Zonenszain-Laiter, 2023). This reductionism can foster depersonalized practices in which nutritional support becomes an end, disconnected from the overall meaning of care.

On the other hand, personalist bioethics proposes an approach centered on the unity, uniqueness, and individuality of the human person (de la Garza & Zonenszain-Laiter, 2022). From this perspective, nutritionists and dietitians are called upon to recognize the terminally ill patient as a subject of rights, with a personal history and significant relationships, whose dignity demands respect even when their decision-making capacity is diminished. This implies integrating clinical, emotional, familial, spiritual, and cultural aspects into nutritional decision-making. In palliative care, this understanding translates into care that prioritizes the meaning of caregiving over the prolonging survival or early death. In this context, nutrition acquires, in addition to its biological dimension, a symbolic and relational value by expressing closeness, accompaniment, and recognition of the other as a person. Thus, the anthropological foundation of personalist bioethics, based in the Boethius's conception of person and Spaemann's reflection on human dignity, offers a solid framework for analyzing nutritional interventions at the end of life. This approach guides professional practice toward the unconditional respect of the patient, avoiding both abandonment and therapeutic obstinacy.

The principles of personalist bioethics –therapeutic proportionality, responsibility, precaution, and freedom–, are developed and constitute fundamental criteria for ethical discernment in the nutritional care of the terminally ill patient.

Therapeutic proportionality

The therapeutic principle of personalism maintains that it is ethically permissible to intervene on a part of the body when the intervention is aimed at the overall well-being of the person (Kuthy et al., 2015). This principle is based on the understanding of the person as a substantial unity of body and spirit, in which the biological, psychological, and spiritual dimensions are not only juxtaposed but also constitutively integrated. Therefore, no clinical action can be justified exclusively by its physiological efficacy, but only by its proportional contribution to the overall well-being of the person.

From this perspective, contemporary palliative care practice has recovered a holistic

understanding of care. The control of signs and symptoms cannot be reduced to physical relief but must address suffering in all its dimensions. Koithan & Taylor-Swanson (2025) propose a model that recognizes the terminally ill patient not as an isolated organisms requiring fragmented technical interventions, but as a person who experiences illness within a biographical history, affective bonds, and a horizon of meaning. Therefore, therapeutic proportionality requires discerning whether an intervention promotes an integral balance.

Regarding clinical nutrition, this principle has special relevance. Nutrition –whether oral, enteral, or parenteral– is not only a technical procedure; it is a form of care aimed at promoting the well-being and quality of life. However, when the disease is in an advanced stage and life expectancy is limited, it is necessary to assess whether artificial nutritional support contributes to the person's well-being or, conversely, becomes a form of therapeutic obstinacy. The principle of proportionality does not require maintaining treatments that biologically prolong the dying process without improving the patient's well-being; however, it also does not justify the omission of basic care. Prudent decision-making requires integrating clinical criteria –such as prognosis, disease reversibility, symptom burden, and risk of complications–; ethical criteria –such as therapeutic objective and respect for dignity–, and the patient's wishes. With this comprehensive consideration of the patient, it is possible to avoid both therapeutic obstinacy and abandonment, while preserving the person's ontological dignity in the end-of-life stage.

Principle of responsibility

In palliative care, the principle of responsibility takes on ethical significance. Healthcare professionals –and, clinical nutritionists, in particular– are frequently required to make decisions that extend beyond the technical assessment of whether a nutritional intervention should be initiated, continued, or withdrawn. These decisions also demand careful ethical deliberation regarding their implications for the individual's well-being.

The principle of responsibility in personalist bioethics is based on the personal nature of the human being. Only a free person can be held responsible, since responsibility arises from freedom and represents the practical exercise of reason directed toward the good. In this sense, responsibility is fundamentally a response to the intrinsic value of another person (de Siqueira, 2001). Within healthcare, this means that every clinical decision should be guided by respect for and promotion of the patient's inherent dignity, regardless of prognosis or life expectancy. Accordingly, the principle of responsibility guards against two opposing forms of reductionism. The first is biological reductionism, in which nutritional interventions are maintained to preserve physiological functions without regard for patient suffering or the absence of significant benefit. The second is the unjustified withdrawal of basic care based exclusively on a perceived poor quality of life, evaluated under external or social parameters.

Individuals with advanced disease, including advanced cancer, progressive neurodegenerative disorders, or severe frailty associated with aging, the decision to provide enteral or parenteral nutrition requires prudent evaluation that goes beyond the technical assessment. The principle of responsibility requires an assessment of the patient's prognosis, the objectives of care –whether curative or palliative– and the proportionality between the expected benefits and the possible burdens of nutritional support. Consideration must be given to both the patient's previously expressed wishes and the potential impact of nutritional decisions on their overall suffering, understood in its biological, psychological, and spiritual dimensions. In this sense, nutritional care remains focused on the patient's well-being, safeguarding human dignity throughout advanced illness.

Responsibility in healthcare is not isolated, but relational. In palliative care, decisions must be made within a framework of interdisciplinary deliberation, where nutritionists

and dietitians contribute their specific expertise in metabolism and energy balance, in dialogue with the medical team, the patient, and the family. Responsibility also includes truthful and prudent communication; explaining therapeutic limitations, avoiding false expectations, and providing emotional support to those facing the end of life (Zapata-Ospina, 2019).

Principle of precaution

Clinical decision-making unfolds within a context of uncertainty; prognostic uncertainty, variability in response to nutritional interventions, organic fragility, and the emotional vulnerability of the patient and their family. In this context, Roqué et al. (2015) suggest that the precautionary principle should be understood as the virtue of prudence rather than a restrictive attitude. According to the Aristotelian tradition, a prudent person is one capable of deliberating correctly about what is good and appropriate for others.

Prudence, understood as right reason applied to action, integrates intelligence and will; one the truth is known, it guides action toward the good (de la Garza & Zonenszain-Laiter, 2023). In palliative care, this discernment is not focused on preserving organ function, but on considering the unity of the person in their biological, psychological, and spiritual dimensions.

In situations of clinical uncertainty, it is necessary to discern which intervention is most proportionate to promote the person's well-being, considering the benefits against the potential risks. This exercise in prudence requires integrating accumulated experience, ethical reflection, and an assessment of the consequences that nutritional decisions may have on the patient's quality of life and well-being (de la Garza & Zonenszain-Laiter, 2023).

Memory refers to the patient's medical history, disease trajectory, and previous response to nutritional interventions. Reflection requires assessing the patient's current condition, functional capacity, and the presence of signs and symptoms such as anorexia, dysphagia, or cachexia, as well as palliative care objectives focused on well-being. Planning involves reasonably anticipating the possible consequences of initiating, maintaining, or discontinuing enteral or parenteral nutrition, the risk of infection, metabolic complications, organ overload, or disproportionate prolongation of the dying process.

Principle of freedom

The advanced illness can limit physical and cognitive abilities without diminishing the patient's dignity or personal status. In fact, although functional autonomy decreases, respect for their personhood remains. Therefore, freedom should not be understood as operational independence, but as an expression of personal interiority; the capacity to consent, accept, discuss, and participate in decisions that affect one's own care process.

In end-of-life nutritional care, this principle implies that decisions regarding the initiation, continuation, or discontinuation of an intervention should not be imposed from a technical standpoint. The professional does not replace the patient's wishes but rather accompanies them with truthful, appropriate, and judicious information. The patient's freedom is authentically exercised when they have the necessary elements to deliberate, understand the scope of the interventions, and consciously express their consent or refusal. From an Aristotelian perspective, freedom is neither absolute nor arbitrary; it is intrinsically linked to the truth of the human good (Dietrich, 2004). Therefore, respecting freedom does not mean validating any decision disconnected from the person's well-being. The healthcare professional's task is to reconcile respect for self-determination with the responsibility not to cooperate in acts that violate human dignity or cause disproportionate suffering. Clinical deliberation becomes a space of encounter between the patient's freedom and the professional's prudence, both oriented toward the

common good.

In terminal illness, complex decisions arise regarding the continuation of artificial nutrition. Freedom must be exercised within a framework of support and care, avoiding both paternalism and abandonment. Ultimately, the principle of freedom, understood from a personalist anthropology, reminds us that people in palliative care are not objects of intervention, but subjects of care. Nutritional care, even in the end-of-life stage, must respect their capacity to make decisions, integrating truth, prudence, and support. Freedom is not defined as isolated Independence, but as an expression of personal dignity that endures until the end of life.

Ethical considerations and recommendations

The integration of the principles of therapeutic proportionality, responsibility, precaution, and freedom offers nutritionists and dietitians a coherent ethical framework for the care of terminally ill patients. Therapeutic proportionality reminds us that all nutritional interventions must be oriented toward the well-being of the person in their biological, psychological, and spiritual unity; responsibility suggests responding to the patient's well-being, avoiding both therapeutic obstinacy and abandonment; freedom recognizes the patient as a moral subject capable of participating in decisions that affect their care; and precaution, basis in prudence, guides discernment in contexts of clinical uncertainty.

In the professional practice of nutritionists and dietitians in palliative care, this synthesis translates into the recommendations:

1. Assess the proportionality of nutritional intervention, considering prognosis, reversibility, symptom burden, and benefits.
2. Integrate the biopsychosocial and spiritual dimensions of the patient into the nutritional assessment, recognizing that feeding is also an act of relational and symbolic care.
3. Deliberate in an interdisciplinary manner, avoiding isolated decisions and fostering dialogue among the healthcare team, the patient, and the family.
4. Exercise clinical prudence, anticipating risks and avoiding interventions that offer no benefit in contexts of high vulnerability.
5. Distinguish between comprehensive basic care and isolated technical measures.

Conclusions

The question, "To feed or to care?", presents an ethical challenge: discerning when nutrition constitutes genuine care and when it may become a disproportionate intervention. From the perspective of personalist bioethics, nutritional care in palliative settings requires acting in accordance with the person's overall well-being, respecting their inherent dignity, and avoiding both negligent omission and disproportionate intervention. By integrating the principles of therapeutic proportionality, responsibility, precaution, and freedom, nutrition professionals assume an essential role in accompanying patients at the end of life. Their role extends beyond calculating energy requirements or selecting methods of nutritional support; it involves actively participating in prudent ethical deliberation aimed at promoting the patient's well-being. Thus, nutrition is understood as an act of care that respects the limits of the human condition and recognizes that, although it is not always possible to cure, it is always possible to care with dignity.

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