Ethics and Therapeutic Skepticism

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The proposal in this issue by Dr Yarborough,[1] that physicians are obligated to *offer* but not to *administer* food and fluids to patients, seems a useful contribution to the ongoing ethical debate over forgoing nutrition and hydration. Moreover, it suggests one aspect of medical ethics where family physicians may have some special insights to offer.

The distinction between offering and administering food and fluids speaks to an underlying tension in that debate which is felt by most health care professionals. On the one hand, there does seem to be something uniquely basic about food and fluids, such that failure to provide them is somehow different from withdrawing or withholding other forms of medical care such as respirators or antibiotics. On the other hand, there seems to be little useful analogy between offering a canteen of water to a thirsty traveler in the desert and putting an intravenous line into a moribund hospice patient; or between offering bread to a starving peasant in Ethiopia and inserting a nasogastric tube into an irreversibly comatose patient. If our duty is to offer rather than to administer food and fluids, we can see that our basic impulse toward our hungry and thirsty fellow beings may occasionally be misapplied—either because a person has refused that aid, or because disease or its complications have rendered the patient incapable of "receiving" that aid in any meaningful sense.

In suggesting that the so-called duty to provide food and fluids to all patients really amounts to an insistence that patients be forced to eat, Yarborough points out the unintentional arrogance of that ethical posture. I suggest that this arrogance has two strands: the *interpersonal arrogance* of assuming that physicians, not patients, should decide who will eat and when; and the *therapeutic arrogance* of assuming that medical technology has the power to force fluids and nutrients into almost any afflicted body and thereby to confer significant life extension. Interpersonal arrogance among physicians has been widely condemned as inappropriately paternalistic. But therapeutic arrogance has received less criticism because it is usually implicit in the discussion and because it fits so well with the mythologies of modern medicine shared by physicians and patients alike.

Another recent and useful example of debunking therapeutic arrogance is the suggestion by Hadorn[2] that the standard "do not resuscitate" or "DNR" order be replaced with "do not *attempt* resuscitation (DNAR)." The order on the patient's chart, "do not resuscitate," carries the strong symbolic message that resuscitation works, and that by refusing it, the patient has elected to forgo a clearly beneficial therapy. This message squares poorly with actual data demonstrating (as Hadorn notes) as low as a 10% or 20% success rate for resuscitation in many in-hospital settings. By strutting around hospital corridors and giving orders such as, "Mr. Jones is DNR" or "Mrs. Smith is a full code," we conveniently close our eyes to the real limitations of our favorite technologies. Does "we must provide food and fluids for all patients" reflect the same unwillingness to face our limits?

One of the most pertinent observations on the food-and-fluids debate was made to me by a well-known medical ethicist, who recalled an elderly aunt of his upon whom had fallen the duty of caring for several even more elderly relatives in their terminal illnesses:

"Of course in those days almost everyone died at home, not in the hospital. My aunt would give them soup and bread until they could not swallow that. Then she would give them broth, by spoonfuls. When they could not manage even that, she would be content with giving them sips of water. And soon after that they died.

"Now it does not take a medical degree to realize in retrospect that every one of those relatives died in a state of malnutrition and dehydration. But they gave no sign whatever of suffering. Indeed, they died precisely the 'natural death,' at home amid loved ones, which is the envy of all too many of today's hospitalized patients and their physicians. And so when I hear today that we are not doing our duty to the dying unless we inflict IVs and feeding tubes on them, I have to be skeptical."

Good ethical reasoning demands rejection of both types of arrogance—an appreciation of both the rights of patients to be involved in choices, and also the inherent limits

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of medical technology. Family physicians may be no better than other human beings, but our training stresses the critical evaluation of technology before it is recommended for our patients, and the experience of caring for many people with undifferentiated and ill-defined complaints over extended periods is more apt to promote humility than the reverse. When family physicians approach ethical problems in medicine—as they increasingly will, through institutional modalities such as hospital ethics committees—they may bring to bear a healthy therapeutic skepticism that can serve as an antidote to some of the worst excesses of arrogance.

References

1. Yarborough M: Why physicians must not give food and water to every patient. J Fam Pract 1989; 29:683–684
2. Hadorn DC: DNAR: Do not attempt resuscitation. N Engl J Med 1989; 320:673