And it would be thought that in the matter of food, we should help our parents before all other, since we owe our nourishment to them, and it is more honorable to help in this respect the authors of our being even before ourselves.

Aristotle

INTRODUCTION

The spirited public and professional debate in the ethics of end-of-life care and the termination of treatment has produced an extensive literature. While many positions on individual issues have been articulated, a professional, public and legal consensus has been reached on fundamental concepts of ethical analysis. This consensus, represented by the 1983 President's Commission report, has two parts. First, the patient is seen as an autonomous moral agent, with decisive moral authority for evaluating and choosing among treatment options. Second, medical treatments are to be weighed according to their consequences (burdens and benefits) for the individual patients.

This model for resolving complex medical ethical decisions fits the times well. It is compatible with: (1) the medical profession's belief that the physician and patient are engaged in the task of improving individual well-being, (2) civil and legal traditions emphasizing the use of individual rights to decide controversial decisions, and (3) a political and cultural belief that ethical rightness cannot be securely found outside the individual's own act of existential affirmation of an action as good.

This paper will consider the application of the consensus position to the decision to employ medically futile feeding for terminally ill and immediately dying patients at the request of their family. Such feeding is medically futile in the sense that nourishment cannot significantly prolong life and in the sense that these patients do not experience anorexia as either hunger or thirst. Thus, this paper will not address the provision of nourishment to non-dying patients in persistent coma. In the situation where the treatment proposal is medically incomprehensible, the misapplication of the consensus positions may lead to a profound misunderstanding of the patient's interests and of the family preferences for end-of-life care.
SAMPLE CASES

Case 1: A 47 year old man dying of widely disseminated colon cancer was returned to a hospital hospice after sustaining a cancer-related hip fracture while at home under the care of a home hospice program and his wife and sister. After ten days of taking only liquids from his deeply religious, constantly attendant wife and nurse-sister, he became obtundated and near death. Even though his wife and sister acknowledged that he was dying and not conscious of hunger or thirst, they asked that intravenous fluids be provided during the last hours of his life. A slow intravenous infusion was given for 36 hours until the patient died comfortably with his family at the bedside.

Case 2: An anorectic 67 year old man was dying of a widespread lung cancer in a hospital hospice. For six weeks, he had refused food from hospital staff, taking it only when presented by his elderly, constantly present, and deeply religious 88 year old mother. She assisted with his hygiene, read to him, and viewed feeding as a primary caring duty. Early in his hospitalization, he had tried and rejected nasogastric nourishment stating that he did not want his life to be prolonged, that the tube irritated his nose, and that it interfered with socializing with other patients on the ward. When he became bedbound, he asked that intravenous fluids be given for thirst. He became comatose and no longer able to take the food his mother offered. His anguished mother, acknowledging that nourishment would not delay his imminent death, asked that a nasogastric tube be placed so that she could continue to feed her dying son. In recognition of the close relation between the mother and son, the fact that the son had exceptionally taken nourishment to please his mother and that the tube would neither extend his life or cause pain in his comatose state, a tube was placed. He died 18 hours later.

These cases raise the issue of whether a family request to provide medically futile nourishment to anorectic and dying patients should be honored. In the first case, the patient had expressed no clear preference. In the second, the patient had previously rejected enteral alimentation. In both cases, family have been conscientiously attentive to the patient's needs and feeding throughout their illnesses.

THE CONSENSUS POSITION ON NOURISHMENT

The emerging consensus of ethicists, medical associations, and appellate courts is that nourishment is a medical treatment. As