

FOOD and WATER

(Excerpts from “A Good Death,” by Charles Meyer)

Food and water are things that are taken orally, by mouth, and swallowed. They produce pleasant sensations on the palate and connect with fond memories of meals in the past. They may alter the patient’s mood or attitude, or be the one thing that makes him or her feel normal for a few moments, or provide the joy of sharing a meal with loved ones and friends. When caregivers use words like “food” and “water” families think “dinner.” And more than that, they think and feel “nurture,” “caring,” “love”. We have incredibly powerful emotional associations with “food and water.” We think of feeding helpless babies or old people who can no longer feed themselves. We think of feeding the hungry, of Jesus’ admonition to us to feed those less fortunate than ourselves. We feel immediately protective and think that food is a basic human right that must be provided even to those who are in terminal conditions. And we think that, if we withdraw or withhold “food and water” from our dying loved one, he or she will “starve to death.”

In the normal process of dying, patients quit eating and drinking. This is extremely important to remember when dealing with nursing home patients. One study looked at such patients who were walking and talking one week and dead three weeks later, because they had quit eating and drinking for no apparent reason. They were not hungry or thirsty, refused all requests from staff and families to eat or drink (so the staff and families would feel better), became azotemic (kidneys shut down) and died. It was as though they woke up one morning and a chromosome timer in their brain clicked, indicating it was time to go. Often, families, nursing administrators, physicians, and caregivers have a hard time letting this natural process occur. The truth is that when we demand that terminal patients receive artificial nutrition/hydration (AN/H), we often cause more harm than good, the result of which is a “bad death” or certainly a worse one than the person would have had otherwise.

Food and water are meant to be ingested by mouth. IV fluids and tube feedings are artificial hydration and artificial nutrition being pumped by a machine into a body to keep a body functioning (not necessarily “alive”). If you think it’s food, try it. It does not provide the patient any satisfaction, comfort or pleasant memories. It does not alter mood or make the patient feel normal.

When we withdraw AN/H from patients in terminal conditions, azotemia begins. They do not experience hunger or thirst, though they might like their mouths moistened with swabs or ice chips. The patient begins to dehydrate and expel fluids. For patients with brain swelling, this process sometimes results in temporary clarity because the edema (fluid) drains and decreases the pressure on brain tissue. As dehydration occurs, waste products build up in the body and serve a natural analgesic to insulate the body from pain.

The patient becomes tired, sleepy, less conscious, drops into a coma where all pain ceases, and eventually dies. This process can take from a few days to a few weeks, depending on the debility of the body and the advancement of the disease. If there is any pain or discomfort from the disease during this time, it can be pacified with the large range of pharmaceuticals available from aspirin to morphine, with many routes of administration, from sublingual to IV, to patch, to suppository. Indeed, azotemia results in a good death.

So what happens if we maintain AN/H in the patient with a terminal condition? Studies have shown we can create a bad death. As we pump nutrition and fluids into the body that is trying to throw them off and die, we create what are called, “clinical sequelae,” things that happen as a result of our treatment – that do NOT happen with azotemia. The constant influx of fluids means that the patient will have to be catheterized and suctioned. As kidneys shut down and fluid keeps coming in, the fluids begin to seep into bloating tissues. This condition is very painful and requires increased narcotic medication. Artificial nutrition can result in intractable (unstoppable) diarrhea, and it can wake up the patient so he/she can fully (and unnecessarily) experience suffering and death.

“Life support,” “food and water,” “feeding tube,” all can come with vast amounts of emotional baggage that get in the way of seeing the situation accurately, and they result in treatment decisions that may cause harm, prolong dying, and do not honor the wishes of the patient. Most of what is done in medicine is aimed at having an effect on the body, organ, or system. But for patients in terminal conditions, the question is not whether you can produce an effect with the IV or ventilator or AN/H, the question is whether or not this treatment or procedure results in any benefit to the patient at all (as the patient would define it). If not, comfort care is in order.

Many people worry about removing treatment of any kind for fear of causing the death of the loved one and feeling as though they have committed murder. It is extremely important to understand the truth about this. When a ventilator is turned off, the cause of death IS NOT turning off the ventilator. The cause of death is pulmonary failure, which was happening before the ventilator was turned on in the first place. When AN/H are removed, the cause of death IS NOT starvation or dehydration. The cause of death is the underlying disease process, or cancer, or heart disease, or lung dysfunction, trauma or whatever. Withdrawing treatment is merely getting out of the way and allowing the natural process of death to occur with as much attention to comfort, dignity, and quality as possible. It is often the most loving (and difficult) thing to do both to honor the wishes of the patient and to come to terms with the inevitability of the death.