

# Voluntary Stopping of Eating and Drinking: An Ethical Alternative to Physician-Assisted Suicide

**T**he polarized debate over physician-assisted suicide (PAS) (now sometimes referred to as assisted dying) has included little discussion on an alternative method for voluntary death – terminal dehydration (Miller, Fins, & Snyder, 2000; Miller & Meier, 1998). With terminal dehydration, competent patients with a terminal or incurable illness seek death by forgoing artificial nutrition and hydration or by ceasing to eat or drink. With accompanying standard palliative care measures, individuals can escape conditions they consider to be worse than death. Clinical, ethical, and policy issues will be analyzed primarily by comparing voluntary stopping of eating and drinking (VSED) to PAS. Recommendations for nursing practice, education, and organizational policy will be provided.

Clinicians with palliative care expertise generally agree how to respond to requests for aid in dying (Schwarz, 2014). They begin to explore the reasons behind the request, intensify efforts to relieve pain and suffering, consult specialists for relief of psychological or spiritual suffering, commit to nonabandonment, and seek mutually acceptable solutions for the patient's suffering (Schwarz, 2014). If unacceptable suffering persists despite all efforts, then decisionally capable patients should be informed about all legal options that permit a hastened death (Hospice and Palliative Nurses Association [HPNA], 2011). These options include withholding or VSED, withdrawing life-sustaining interventions, and sedation to unconscious for relief of intractable suffering (HPNA, 2011; Schwarz, 2007). The American Nurses Association (ANA, 2013), HPNA (2011), and Oncology Nursing Society (2010) do not support assisted dying. However, all recognize nurses practicing in a state where PAS is legal will have to decide if their own moral value systems do or do not allow them to be involved in providing care for a patient who has chosen to end his or her life through PAS.

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## Ethical Differences in PAS and VSED

Is PAS – killing oneself by ingesting prescribed lethal medication – primarily dissimilar from refusal of life-sustaining treatment or VSED, to which every person has a legal and ethical right? All three of these choices must meet the test of informed consent: patient capacity, voluntariness, and comprehension of the benefit, burden, and consequences (ANA, 2015). Though the outcome in all three is death, nurses have an obligation to inform patients of all options, even PAS if legal in states where they practice. Key differences between PAS and VSED are summarized in Table 1.

## Physician-Assisted Suicide

When individuals find their quality of life intolerable, as seen most recently in the headline case of Brittany Maynard (Barone, 2014), the option of PAS can be sought. It is legal now in five states: Oregon, Washington, Montana, Vermont, and New Mexico (Eckholm, 2014). Compassion and Choices (2014a) has supported an individual's right to die on his or her terms, beginning with the Oregon campaign. Oregon's Death with Dignity Act, which took effect in 1997, authorizes prescriptions for lethal medication doses when two doctors agree a patient will die within 6 months and is choosing this path freely. In 2013, voters in Vermont approved a law similar to the Washington statute passed in 2008. In response to lawsuits, state courts in Montana in 2009 and most recently in New Mexico have indicated aid in dying is legal, distinguishing it from the crime of assisted suicide. On November 13, 2014, the New Jersey State Assembly voted 41-31 in a bipartisan fashion to pass the Aid in Dying for the Terminally Ill Act (A2270); thus New Jersey is likely to become the sixth state in 2015 (Compassion and Choices, 2014b).

Starks, Dudzinski, and White (2013) wrote an excellent overview of arguments for and against physician aid in dying. The arguments for acceptance of PAS center around respect for autonomy, compassion for unremitting suffering, support of personal liberty vs. the state's interest in preserving life, and justice. Justice requires "we treat all like cases alike;" persons dependent on technology-based life support (e.g., hemodialy-

**TABLE 1.**  
**Comparison of VSED to PAS on Key Differences**

Issues	VSED	PAS
Method	Stopping eating and drinking	Killing oneself by ingesting prescribed lethal medication
Assistance provided	Support of caregivers to manage palliative care needs (e.g., mouth care, turning, etc.)	Supplying the medical means of causing death
Time	1-3 weeks	Within minutes-hours
Outcome	Death through terminal dehydration	Death through overdose of barbiturates

**Sources:** Compassion and Choices of Washington, 2013; Critchlow & Bauer-Wu, 2002; Miller & Meier, 1998; Schwarz, 2014

sis) can refuse this treatment to hasten death. Although individuals with debilitating pulmonary disease or heart failure may not be tethered to a mechanical device, the burden of life nevertheless may exceed their desired quality. The key ethical arguments against PAS are honoring the sanctity of life and professional integrity of professions (do no harm), potential for abuse, and the passive vs. active distinction. The latter addresses actively killing in PAS vs. letting a person die by withholding/withdrawing interventions or VSED.

### Withdrawal of Life-Sustaining Treatment

The courts have stated consistently there is no legal or ethical difference between withholding and withdrawing of life-sustaining interventions. The cases of Karen Quinlan, Nancy Cruzan, and Theresa Schiavo were right-to-die instances that required the withdrawing of life-sustaining treatment (Fine, 2005). In hospitals across this country, clinical decisions to withdraw or withhold treatment occur every day. The informed patient makes a decision not to pursue further treatment or to withdraw treatment already begun (e.g., chemotherapy, left ventricular assist device implantation).

“A valid refusal is sufficient to authorize the withdrawal of treatment, regardless of the clinicians’ judgments concerning the medical or moral appropriateness of the action” (Miller et al., 2000, p. 473). Once the valid refusal is made, the physician has a moral responsibility to honor the refusal and/or transfer the patient to another physician. Nurses also may experience discomfort in honoring a patient’s autonomous choice to allow death. They can voice conscientious objection when their moral integrity is at risk of being compromised and ask for a replacement in the care of the patient (ANA, 2015; Lachman, 2014).

### Voluntary Stopping of Eating and Drinking

Another legal alternative in all 50 states to PAS is VSED; some authors see this simply as a choice of stopping life-sustaining treatment (Lachman, 2010; Miller et al., 2000; Miller & Meier, 1998; Valente, 2004). Food and water are required for life; deciding to forgo these basic elements for continued life support in VSED is done to

hasten death. VSED is a volitional refusal, not the natural desire for decreased food and fluids seen in patients in some terminal conditions. When a person stops eating and drinking, death occurs in 1-3 weeks (Valente, 2004). Support by caregivers is needed to manage the dying process, as the patient lapses into unconsciousness.

The arguments for and against VSED involve the conflicting ethical principles of nonmaleficence and autonomy. Persons who argue against the option of VSED (nonmaleficence) frame the actions taken by the individual as suicide and believe it is morally wrong to be complicit in the care of patients who come to this decision (Jansen & Sulmasy, 2002). Lowey (2001) argued a distinction between physicians recommending VSED and patients who come to the decision on their own. Other authors suggested patients have a right to know they can make this choice and should be informed, as they believe only the person living with a terminal illness can know when the burdens outweigh the benefits of continuing to live (Berry, 2009; Miller & Meier, 1998; Schwarz, 2014). The patient’s option to voluntarily stop eating and drinking is grounded in the ethical principle of autonomy and is supported by statutory and case law (Miller & Meier, 1998).

Physicians’ and nurses’ reluctance in discussing VSED as an option often comes from fear of catalyzing an individual’s action that will hasten death. However, VSED offers the opportunity for change of mind. Often just knowing a way out exists if the dying process is unbearable can provide relief from desperation that could lead to a more violent solution (Schwarz, 2014). These same phenomena exist in the studies of Oregon patients who actually used a barbiturate to end their lives vs. those who did not use; consistently, approximately half of persons who obtained the barbiturate actually used the lethal dose of medication (Lachman, 2010).

The only research found on refusal of food and fluids involved a survey of 307 nurses and 83 social workers who provided direct care for Oregon residents enrolled in hospice (Harvath et al., 2004). No significant difference was found between nurses and social workers in

their support for patients choosing PAS or VSED. More than 75% of participants thought VSED should be an option for patients experiencing physical, psychological, or spiritual suffering; 95.4% would continue to care for patients who choose this option, and 70.7% would consider the option for themselves. Both groups were significantly more supportive of VSED than PAS, with the magnitude of the difference for nurses being larger.

Pope and Anderson (2010) provided an in-depth review of VSED as a legal treatment option at end of life, but their review also offered an excellent comparison to PAS and limiting life-sustaining therapies. They emphasized the importance of educating patients on this choice and honoring appropriate patient requests for VSED. Because of the reluctance of some providers to honor requests for VSED, they suggested, "it may be necessary both to mandate disclosure of VSED as an option and to clarify safe harbor protection for supervising and supporting it" (p. 427).

### Managing the Clinical Nursing Issues of Terminal Dehydration

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Evidence indicates death by terminal dehydration is not painful when resultant discomfort is managed by palliative care measures (Berry, 2009; Critchlow & Bauer-Wu, 2002; Miller & Meier, 1998). Reduction of fluids reduces urine output, gastrointestinal secretions, pulmonary and pharyngeal secretions, and edema. Critchlow and Bauer-Wu (2002) reported studies in which hospice nurses had a positive view of terminal dehydration, while acute care nurses believed patients needed artificial nutrition and hydration. Experienced nurses who had witnessed the dehydration process had significantly more positive perceptions of terminal dehydration than nurses who had not. Biological changes experienced by patients who use VSED to hasten death are due to the functional imbalances created in the body.

The physiological imbalances cause analgesia through acidosis, hypernatremia, hypocalcemia, and cerebral anoxia. As calorie deprivation occurs, ketone production increases, causing a partial loss of sensation. Some ketones have anesthetic effect...Food deprivation in rats [similar process in humans] has been shown to cause an increase in beta-endorphin, a natural opiate, in the hypothalamus and plasma; while water deprivation has caused an increase in dynorphin, an extremely strong opiate. (Critchlow & Bauer-Wu, 2002, p. 34)

These imbalances also produce some potential problematic symptoms that need to be managed for comfort with the dying process. These symptoms include apathy, lethargy, coma, confusion, increased risk for pulmonary embolism and deep vein thrombosis, headaches, nausea and vomiting, muscle cramps, increased risk of urinary tract infections, dysuria, dry

mouth, and thirst. The literature explains both the benefits and drawbacks of terminal dehydration, but benefits outweigh the side effects that can be managed (Critchlow & Bauer-Wu, 2002; Hoefler, 2000). Nurses who receive training from End-of-Life Nursing Education Consortium (ELNEC), sponsored by the American Association of Colleges of Nursing (AACN, 2014), understand and are able to apply clinical and ethical standards to the care of patients choosing VSED.

Compassion and Choices of Washington (2013) provides answers to a list of frequently asked questions on the subject of VSED. Because no one can manage his or her process alone, the suggestion is that a referral to hospice care is made, as hospice staff can provide needed supportive care in the hospital, nursing home, or home using the Medicare billing code for "voluntary starvation" (307.1). All diabetic, heart, and blood pressure medications should be discontinued. Medications for pain and sedation should be continued as suppositories, injection, or skin patches around-the-clock, until the patient becomes unconscious. A sign should be posted on the wall near the patient's bed indicating nothing by mouth, or no food or fluids. Excellent mouth care includes offering peroxide/water rinses or artificial saliva; brushing gums, teeth, and tongue with soft toothbrush or sponge; swabbing mouth with a moist swab; offering small sips of fluid or crushed ice or chips; and using lip moisturizers.

### Clinical, Education, and Organizational Policy Recommendations

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For effective use of the option of VSED, certain clinical, education, and policy parameters should be in place. This ethical alternative to PAS requires nursing knowledge of the option, its ethical acceptance, and the clinical practice knowledge to manage terminal dehydration. A health care organization has the ethical responsibility to provide the needed education, practice setting, and policies to support nurses in meeting the needs of patients choosing VSED. Below are some key recommendations in these arenas.

*Clinical Recommendations* (Compassion and Choices of Washington, 2013; Critchlow & Bauer-Wu, 2002; Schwarz, 2007, 2014; Valente, 2004)

- Assess for decision-making capacity to make a voluntary decision on choices, screening for depression.
- Engage in discussions around diagnosis, prognosis, and goals of care.
- Provide palliative care consultation services for front-line nurses.
- Deliver excellent mouth care needed to reduce thirst.

*Education Recommendations* (AACN, 2014; Compassion and Choices of Washington, 2013; Schwarz, 2014)

- Provide palliative care education to clinical nurses; have a palliative care nurse champion on each unit who has been trained through ELNEC.

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- Educate patients and family members about what to expect as VSED progresses.
- Support palliative care provisions as patient dies, along with family support consistent with the value of patient and family-centered care.

*Organizational Policy Recommendations* (Miller & Meier, 1998; Pope & Anderson, 2010; Schwarz, 2014)

- Require palliative care consultation for all patients who have an expected prognosis of 1 year or less to live.
- Create a conscientious objection policy that identifies and supports a process for persons with moral objections to VSED.
- Craft policy for assessment and protocols when patient is not dying imminently (6 months or less); clinicians need to seek second opinion from specialists skilled in assessment of depression and spiritual suffering.
- Develop protocols for nursing standards of practice for terminal dehydration.

## Conclusion

During the past 30 years, moral progress has been made in expanding the patient's right to control life-and-death decisions. The movement to increase availability of PAS has been part of this changing landscape. The growth of hospice and palliative care, in and out of acute care settings, has made nurses increasingly aware patients can die without being tethered to technology. VSED is a legal and ethical option for patients whose underlying illness has become an intolerable affront to their personhood (Schwarz, 2007, 2014). Nurses are in a unique position to alert patients to this option through their frequent, often intimate discussions with patients. To support the autonomy of patients, nurses need to understand the clinical management of VSED so they can educate patients and families on this option (AACN, 2014; Compassion and Choices of Washington, 2013).

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