The Ethics of Voluntarily Stopping Eating and Drinking

Graciela Ortiz

Abstract. Encouraging VSED (voluntarily stopping eating and drinking) to hasten a patient's death is immoral. The practice results in an obvious conflict between the autonomy of the patient and the principles of beneficence and non-maleficence that must guide the physician and other health care workers. Because VSED is an act of passive euthanasia, it harms the patient and thus compromises the integrity of the physician–patient relationship. Health care providers must avoid any involvement in VSED, whether by providing information about the practice or by administering palliative care while a patient is voluntarily starving and dehydrating himself to death. Instead of cooperating in the evil of euthanasia, health care providers need to advocate for the patient by refusing to do any harm and by addressing the reasons why the patient is requesting a hastened death. *National Catholic Bioethics Quarterly* 16.4 (Winter 2016): 607–617.

Voluntarily stopping eating and drinking (VSED) can be defined as "an action by a competent, capacitated person, who voluntarily and deliberately chooses to stop eating and drinking with the primary intention of hastening death because of the persistence of unacceptable suffering."[1] It is a practice in which the patient is physically able to eat and drink but chooses to forgo nutrition because he no longer wants

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1. Nataša Ivanovic, Daniel Büche, and André Fringer, "Voluntary Stopping of Eating and Drinking at the End of Life: A 'Systematic Search and Review' Giving Insight into an Option of Hastening Death in Capacitated Adults at the End of Life," *BMC Palliative Care* 13.1 (January 2014): 1, doi: 10.1186/1472-684X-13-1.

to live. VSED differs from the "naturally occurring loss of appetite and interest in eating and drinking that frequently and naturally accompanies the final stages of dying."[2] An increasing number of patients, some of whom are not terminally ill, are choosing VSED as a means to hasten death.[3] The widespread growth of this trend raises many ethical concerns.

VSED Is Not Refusal of Medical Treatment

Advocates for VSED equate it with refusal of treatment, which they state patients have a right to do.[4] The provision of food and water is ordinary care, not a treatment or a life-prolonging medical intervention. Providing a person with food and water is the same kind of basic care as giving him shelter or clothing. The *Ethical and Religious Directives for Catholic Health Care Services* (*ERDs*) emphasize that a person has a moral obligation to use ordinary, or proportionate, means of preserving his or her life. Proportionate means are "those that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family."[5]

In 2004, Pope St. John Paul II clarified the Catholic teaching that administering water and food "always represents a *natural means* of preserving life, not a *medical act*," stating that its use should be considered "*ordinary* and *proportionate*, and as such morally obligatory, insofar as and until it is seen to have attained its proper finality."[6] The Congregation for the Doctrine of the Faith (CDF) explains that this proper finality is the hydration and nourishment of the patient so that "in this way suffering and death by starvation and dehydration are prevented."[7]

When a patient engages in VSED, death is caused by dehydration and starvation, not by the progression of the person's underlying disease. Therefore, health care providers who are complicit in VSED engage in a form of euthanasia, which the CDF's 1980 *Declaration on Euthanasia* defines as "an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated."[8] If

2. Judith K. Schwarz, "Exploring the Option of Voluntarily Stopping Eating and Drinking within the Context of a Suffering Patient's Request for a Hastened Death," *Journal of Palliative Medicine* 10.6 (December 2007): 1291, doi: 10.1089/jpm.2007.0027.

3. Judith K. Schwarz, "Hospice Care for Patients Who Choose to Hasten Death by Voluntarily Stopping Eating and Drinking," *Journal of Hospice and Palliative Nursing* 16.3 (May 2014): 126, doi: 10.1097/NJH.0000000000000053.

4. Schwarz, "Exploring the Option," 1289.

5. US Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed. (Washington, DC: USCCB, 2009), dir. 56.

6. John Paul II, Address to the Participants in the International Congress on "Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas" (March 20, 2004), n. 4, original emphasis.

7. Congregation for the Doctrine of the Faith, Responses to Certain Questions of the United States Conference of Catholic Bishops concerning Artificial Nutrition and Hydration (August 1, 2007).

8. CDF, *Declaration on Euthanasia* (May 5, 1980), II.

death incurred by an act is active euthanasia and death incurred through an omission is passive euthanasia, then VSED would be an act of passive euthanasia by which a person is deprived of the food and water that are necessary to maintain life.

Origins of VSED

Since the 1970s, the idea of a right to die and talk about rights of autonomous choice have gained currency, and both have influenced the rise of VSED as an acceptable option for patients who want to hasten death. The idea evolved over time, starting with patients who refused life-prolonging treatments or completed living wills to maintain control over their future health decisions.[9] Then, in 1997, the state of Oregon made it legal for patients to ask their physicians for medication that would kill them, becoming the first state to pass a physician-assisted suicide law. Other states have followed suit. Since physician-assisted suicide remains illegal in many states, however, right-to-die advocates look at VSED as a legal alternative for those who want to hasten death. Compassion and Choices, a sixty-thousand-member volunteer organization formerly known as the Hemlock Society, campaigns for the legalization of euthanasia and has played a critical role in encouraging VSED among patients and promoting its use in hospice and palliative care organizations.[10]

In 2000, Gonzalo Herranz predicted that euthanasia will eventually "become incorporated into palliative medicine."[11] Over a decade later, many health care organizations overtly support VSED in their policies and practices. In October 2011, the Hospice and Palliative Nurses Association released a position statement on the role of nurses when a patient requests a hastened death. The document identifies the legal options for hastening death, including VSED, and explains that nurses have "an obligation to assess and respond to these requests to relieve suffering while respecting dignity and choices … When a request for hastened death is made, the nurse shares information about health choices that are legal and supports the patient and family regardless of the decision that is made."[12] The End-of-Life Nursing Education Consortium, sponsored by the American Association of Colleges of Nursing, also trains nurses to care for VSED patients.[13] More recently, the American Nurses Association has proposed supporting patients who voluntarily stop eating and drinking.[14]

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9. Tom L. Beauchamp, "The Right to Die as the Triumph of Autonomy," *Journal of Medicine and Philosophy* 31.6 (December 2006): 645, doi: 10.1080/03605310601096619.

10. Compassion and Choices, "Voluntarily Stopping Eating and Drinking," October 2016, https://www.compassionandchoices.org/.

11. Gonzalo Herranz, "Euthanasia: An Uncontrollable Power Over Death," *National Catholic Bioethics Quarterly* 6.2 (Summer 2006): 264, doi: 10.5840/ncbq20066251.

12. "Role of the Nurse When Hastened Death Is Requested," position statement, Hospice and Palliative Nurses Association, October 2011, http://www.hpna.advancingexpertcare.org/.

13. Vicki D. Lachman, "Voluntary Stopping of Eating and Drinking: An Ethical Alternative to Physician-Assisted Suicide," *MEDSURG Nursing* 24.1 (January–February 2015): 58, doi: 10.1186/1472-684X-13-1.

14. In 2016, the ANA invited public comments on a draft proposal for revisions to their position statement "Nutrition and Hydration at the End of Life." The revisions

The National Hospice and Palliative Care Organization began as the Euthanasia Society of America and has changed its name several times: Society for the Right to Die, Choice in Dying, Partnership for Caring, and Last Acts Partnership.[15] The current president and CEO of NHPCO, Donald Schumacher, is a past vice-chairman of Partnership for Caring.[16] Because of the organization's history, it is not surprising that in September 2013, NHPCO encouraged its two thousand member hospices to develop VSED policies and guidelines. In that month's membership publication, the NHPCO members' publication, *NewsLine*, featured an article about VSED that includes discussion questions and pro-VSED resources.[17] In March 2014, the NHPCO national management and leadership conference included a session on developing sound VSED policies and procedures to support patients who choose it and their family members, emphasizing that VSED is a legal option in all fifty states.[18]

One of that session's co-presenters, Judith Schwarz, past regional clinical coordinator of Compassion and Choices and author of several journal articles advocating for VSED, says she has helped over one hundred people die by no longer eating or drinking.[19] Compassion and Choices asks interested patients to obtain a referral to hospice and encourages them to let the referring doctor know that they qualify for the hospice benefit, because once they stop eating and drinking, they will have less than six months to live.[20] Hospice staff who are familiar with caring for VSED patients use the Medicare billing code 307.1 for voluntary starvation.[21] This confirms what John Paul II observed and articulated in *Evangelium vitae,* that attacks on life are spreading and receive support from "the involvement of certain sectors of health-care personnel."[22]

include support for patients' VSED decisions. The proposal is no longer available online. For commentary on it, see "NCBC Recommends Public Comment on the Draft Proposal on Palliative Care of the American Nurses Association," National Catholic Bioethics Center, December 1, 2016, http://www.ncbcenter.org/.

15. Ralph A. Capone, "The Rise of Stealth Euthanasia: Imposed Death Disguised as Pain Relief," *Ethics & Medics* 38.6 (June 2013): 2.

16. Tracy Berntsen, "What You Should Know about Hospice Care," *Imposed Death: Euthanasia and Assisted Suicide* (Minneapolis: Human Life Alliance, 2011), 8, https://www.humanlife.org/.

17. Patrick T. Smith et al., "VSED and Hospice Care: A Case Study," *NewsLine*, September 2013, 10–13.

18. Timothy Kirk et al., "Voluntarily Stopping Eating and Drinking: An Ethical Conversation about Organizational Policy Development" (PowerPoint presentation, Twenty-Ninth Management and Leadership Conference for the National Hospice and Palliative Care Organization, National Harbor, MD, March 28, 2014), http://nhpco.confex.com/.

19. Nick Tabor, "The Nurse Coaching People through Death by Starvation," *Daily Beast*, November 17, 2014, http://www.thedailybeast.com/.

20. Patients Rights Council, "Voluntarily Stopping Eating and Drinking: Important Questions and Answers," March 2013, 4–5, http://www.patientsrightscouncil.org/.

21. Lachman, "Voluntary Stopping of Eating and Drinking," 58.

22. John Paul II, *Evangelium vitae* (March 25, 1995), n. 17.

In medical ethics, a significant shift in the emphasis on autonomy occurred with the publication of Tom Beauchamp and James Childress's *Principles of Biomedical Ethics* in 1979.[23] Until then, most physicians adhered to the Hippocratic Oath, which emphasizes the principle of beneficence, by which the physician, within the limits of his ability and judgment, is always to act for the good of the patient. [24] The oath is also based on the principle of non-maleficence, which instructs the physician *primum non nocere*, or first do no harm.[25] By taking this oath, physicians made a promise not to harm the patient, which includes avoiding acts of euthanasia even if patients request them.[26]

In their book, Beauchamp and Childress coin the term known in contemporary bioethics as principlism,[27] which identifies four principles of bioethics—autonomy, beneficence, non-maleficence, and justice—but gives primacy to the principle of patient autonomy.[28] Principlism started to change how medicine was practiced, and the Hippocratic physician–patient relationship began to be viewed as paternalistic.[29] As patient autonomy displaced the Hippocratic ethic of beneficence as the guiding principle of bioethics, troubling practices such as VSED have been introduced.

When Autonomy Does Harm

For the most part, the debate on euthanasia has focused on autonomy, and its eclipse of other ethical principles has significant ramifications. The Hippocratic Oath emphasizes the physician's extensive specialized training, which he can draw on to suggest treatment options, whether or not the patient agrees with him about the best course of action. Beauchamp and Childress accuse the Hippocratic Oath of paternalism, which they define as "the intentional overriding of one person's known preferences or actions by another person, where the person who overrides justifies the action by the goal of benefiting or avoiding harm to the person whose preferences or action are overridden."[30] As Janet Smith notes, they argue that "the harm that comes to a patient through denying the patient's autonomous choice outweighs

23. Mary Diana Dreger, "Autonomy Trumps All: Medicine Loses Its Grounding in Science," *National Catholic Bioethics Quarterly* 12.4 (Winter 2012): 654, doi: 10.5840/ncbq20121249.

24. "Hippocratic Oath and Autonomy," Institute of Catholic Bioethics (blog), January 28, 2009, http://sites.sju.edu/.

25. Patrick Guinan, "Autonomy Has Not Killed Hippocrates," *National Catholic Bioethics Quarterly* 9.4 (Winter 2009): 682, doi: 10.5840/ncbq2009946.; "Hippocratic Oath and Autonomy," Institute of Catholic Bioethics; and Thomas Pitre, "Palliative Sedation at the End of Life: Uses and Abuses," *Linacre Quarterly* 76.4 (Winter 2009): 396 , doi: 10.1179/002436309803889034.

26. Patrick Guinan, "Hippocratic and Judeo-Christian Medical Ethics Defended," *National Catholic Bioethics Quarterly* 8.2 (Summer 2008): 251, doi: 10.5840/ncbq20088255.

27. Guinan, "Autonomy Has Not Killed Hippocrates," 686.

28. Dreger, "Autonomy Trumps All," 660.

29. Guinan, "Autonomy Has Not Killed Hippocrates," 686.

30. Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 5th ed. (New York: Oxford University Press, 2001), 176, 178.

all other goods."[31] This argument dismisses the fact that a patient may be anxious or depressed, and thus inclined to make a self-destructive decision. James Knight notes that "the principle of respect for autonomy interprets the best interest of the patient exclusively from the perspective of the patient, as the patient understands his situation."[32] This interpretation does not take into account the fact that patients who are sick sometimes cannot see past the present situation, or that some health care decisions are morally wrong.

How can a physician participate in or condone an act that harms a patient? Doing so goes against what it means to be a physician and to provide care. To do harm or to allow a patient to do harm to himself is not good care. With the shift in focus to the principle of autonomy, the patient is allowed to "define his own good," even if this means selecting "a therapeutically harmful option" like VSED.[33]

Does respect for a patient's autonomy mean that the physician needs to comply with his wishes, decisions, and actions? We need only look to the *ERDs*, which assert that "the truth that life is a precious gift from God has profound implications for the question of stewardship over human life. We are not the owners of our lives and, hence, do not have absolute power over life."[34] Lois Snyder and Daniel Sulmasy stress that "both society in general and the medical profession in particular have important duties to safeguard the value of human life."[35] The *ERDs* point out that the right to life includes a right to adequate health care.[36] Giving patients the option of VSED and participating in the process is not good health care. There are limits on autonomy, such as when the patient requests something that "violates the physician's moral values, harms someone else, [or] … results in harm to the patient,"[37] "violates good medical or professional practice, or clearly is not in the patient's best interests."[38] Thomas Pitre declares that "the profession of medicine needs more than ever before to be grounded in sound ethical and moral decision making."[39]

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31. Janet Smith, "The Preeminence of Autonomy in Bioethics," in *Human Lives: Critical Essays on Consequentialist Bioethics*, ed. David S. Oderberg and Jacqueline A. Laing (New York: St. Martin's Press, 1997), 192, discussing the fourth edition of Beauchamp and Childress's *Principles of Biomedical Ethics*, doi: 10.1007/978-1-349-25098-1_11.

32. James A. Knight, "Ethics of Care in Caring for the Elderly," *Southern Medical Journal* 87.9 (September 1994): 910, doi: 10.1097/00007611-199409000-00010.

33. Dreger, "Autonomy Trumps All," 655; and Patrick Guinan, "Can Principlism Save Medical Ethics?," *National Catholic Bioethics Quarterly* 2.2 (Summer 2002): 233, doi: 10.5840/ncbq20022251.

34. USCCB, *Ethical and Religious Directives*, part 5, introduction.

35. Lois Snyder and Daniel P. Sulmasy, "Physician-Assisted Suicide," *Annals of Internal Medicine* 135.3 (August 7, 2001): 212.

36. USCCB, *Ethical and Religious Directives*, part 1, introduction.

37. Edmund Pellegrino, "The Catholic Physician in an Era of Secular Bioethics," *Linacre Quarterly* 78.1 (Spring 2011): 19, doi: 10.1179/002436311803888465.

38. Edmund Pellegrino, "Some Things Ought Never Be Done: Moral Absolutes in Clinical Ethics," *Theoretical Medicine and Bioethics* 26.6 (December 2005): 479, doi: 10.1007/s11017-005-2201-2.

39. Pitre, "Palliative Sedation," 405.

The physician–patient relationship is based on trust. If a physician offers a patient the option to VSED, the patient can no longer trust that the physician has his best interest in mind and will do no harm. Offering an act of passive euthanasia erodes the trust between the physician and the patient, which John Paul II so eloquently describes in *Evangelium vitae*: "Thus the life of the person who is weak is put into the hands of the one who is strong … and mutual trust, the basis of every authentic interpersonal relationship, is undermined at its root."[40]

In the medical profession, physicians are never to abandon their patients. In certain circumstances, when his best judgment is in conflict with the patient's wishes, the physician may need to remove himself from his patient's care in order to stay true to his principles,[41] such as when the patient chooses to voluntarily stop eating and drinking. This is not abandonment. True abandonment of the patient occurs when the physician cooperates in VSED or another act of euthanasia, because by so doing he tells the patient that his life is not worth living.[42]

Informing Patients about VSED

Some people claim that physicians have an ethical duty to inform ill patients about their right to VSED.[43] The *ERDs* make clear that patients should be "offered the appropriate medical information that would make it possible to address the morally legitimate choices available to them."[44] This should not include counseling on VSED. Since this practice is currently not standard care in the United States, physicians do not have an "obligation to inform or educate their patients about it."[45] Timothy Quill and Ira Byock emphasize the importance of offering information about cessation of eating and drinking "when patients express fears about dying badly or explicitly request a hastened death because of unacceptable suffering," but they are also quick to point out that doctors must be sensitive when they convey the information, because "some patients may consider discussion of thse options coercive, potentially requiring them to justify a decision to continue living."[46] The patient may view the

40. John Paul II, *Evangelium vitae,* n. 66.

41. Edmund D. Pellegrino, "Toward a Reconstruction of Medical Morality," *American Journal of Bioethics* 6.2 (March–April 2006): 69, doi: 10.1093/jmp/4.1.32.

42. Herranz, "Euthanasia," n. 269.

43. Ira R. Byock, "Patient Refusal of Nutrition and Hydration: Walking the Ever-Finer Line," *American Journal of Hospice and Palliative Care* 12.2 (March–April 1995): 12; Schwarz, "Hospice Care," 128; and Kathryn L. Tucker, "The Campaign to Deny Terminally Ill Patients Information and Choices at the End of Life," *Journal of Legal Medicine* 30.4 (October–December 2009): 506, doi: 10.1080/01947640903356183.

44. USCCB, *Ethical and Religious Directives*, dir. 55.

45. Lynn A. Jansen is among authors who assert that physicians do have this obligation: "Voluntary Stopping of Eating and Drinking (VSED), Physician-Assisted Suicide (PAS), or Neither in the Last Stage of Life? PAS: No; VSED: It Depends," *Annals of Family Medicine* 13.5 (September–October 2015): 411, doi: 10.1370/afm.1849.

46. Timothy E. Quill and Ira R. Byock, "Responding to Intractable Terminal Suffering: The Role of Terminal Sedation and Voluntary Refusal," *Annals of Internal Medicine* 132.5 (March 7, 2015): 412, 10.7326/0003-4819-132-5-200003070-00012.

physician's offer of VSED as a suggestion that his life may not be worth living or that it is too financially, physically, or emotionally burdensome on his family, the physician, and society at large.

The relationship a patient has with his doctor influences the patient's decision making. Patients and their family members look to doctors for advice about their options. As Diane Meier points out, "given the degree of psychological dependency of a very ill patient upon his doctor, the potential for subtle and unintentional influence is troubling."[47] Health care providers must be careful to avoid sending the message that a patient's life is "not of sufficient value to fight for."[48]

VSED and the Principle of Cooperation (Complicity)

The importance of physician involvement in VSED has been emphasized in the literature.[49] Specifically, physicians are expected to educate patients about VSED as "a response to suffering,"[50] and help the family "address any unforeseen complications" that arise.[51] Although the patient's refusal of food and fluids technically does not require the physician's participation, in practice "honoring the decision requires the support of the family, physician, and health care team who must provide appropriate palliative care" throughout the process.[52] Health care providers with patients who choose VSED are expected to assure patients that they will provide intensive symptom management if VSED is chosen, educate patients and their families about what to expect as VSED progresses, provide continued presence and support as the patient dies, and provide bereavement support to relatives after death.[53]

Patients who request VSED want to maintain autonomy over their medical decisions with collaboration and support from their health care providers, family members, and other caregivers.[54] Quill and Byock claim that when a physician cooperates in a patient's decision to hasten death by VSED, it honors the patient's

47. Diane E. Meier, Hattie Myers, and Philip K. Muskin, "When a Patient Requests Help Committing Suicide," *Generations* 23.1 (Spring 1999): 67.

48. Ibid., 64.

49. See, for example, Mohamed Y. Rady and Joseph L. Verheijde, "Distress from Voluntary Refusal of Food and Fluids to Hasten Death: What Is the Role of Continuous Deep Sedation?," *Journal of Medical Ethics* 38.8 (November 2011): 511 , doi: 10.1136/medethics-2011-100278; Timothy E. Quill, "Physician-Assisted Death in the United States: Are the Existing 'Last Resorts' Enough?," *Hastings Center Report* 38.5 (September–October 2008): 19 , doi: 10.1353/hcr.0.0051; Jansen, "Voluntary Stopping," 410; Wesley J. Smith, "The Ethics of Food and Drink," *Weekly Standard*, July 28, 2014, http://www.weeklystandard.com/; and Schwarz, "Exploring the Option," 1291.

50. USCCB, *Ethical and Religious Directives*, dir. 55; and Jansen, "Voluntary Stopping," 410.

51. Quill, "Physician-Assisted Death," 19.

52. Quill and Byock, "Responding to Intractable Terminal Suffering," 410.

53. Collins, "Voluntarily Stopping Eating and Drinking."

54. Smith, "Ethics of Food and Drink."

decision,[55] which places patient autonomy over all other ethical considerations. Lynn Jansen emphatically refutes this line of reasoning in her article "No Safe Harbor":

> The issue of complicity is relevant to medical ethics because physicians, like everyone else, are moral agents. To maintain their moral integrity, they must make decisions that are in line with their best moral judgment. It is simply an error to think that physicians can avoid making moral judgments altogether and thereby avoid the issue of complicity. Even if a physician were to decide that she should always defer to the preferences of her patients, this decision itself would rest on a moral judgment about the importance of respecting the preferences of patients. It is also an error to think that physicians should not be too concerned with their own moral integrity. The fact that a physician occupies a professional role does not free her from the responsibilities of being a moral agent. Like others, physicians have a responsibility to avoid participating in wrongful practices.[56]

By informing a patient of his "legal right to engage in VSED," the physician "collaborates with [the patient] in reaching this decision."[57]

To explain how the physician is implicated in the patient's decision, we need to examine the principle of cooperation, also called the principle of complicity. This principle helps us to understand when we are engaged in wrongdoing, which includes not only assisting others in wrongdoing but also advising them to engage in wrongdoing and providing them with information that will assist or tempt them to engage in a wrong action. When a physician advises his patient that refusing food and fluids is an "acceptable response" to suffering, the physician "expresses approval, whether explicit or implicit," of VSED.[58] Jansen illustrates the principle of complicity when she says,

> It is vital to understand that one can assist another in an act of wrongdoing even if one only provides him or her with information. For instance, a bank employee who provides information to potential thieves about the bank's security system may claim truthfully that he never intended for them to act on the information. Still, if the thieves were to rob the bank, then he would be complicit in their act of wrongdoing. He would be able to avoid the charge of complicity only if he were non-negligently unaware of their plans or had a compelling justification for providing them with the information. [59]

Because acting in this way compromises the integrity of the physician–patient relationship, health care providers need to stay away from any involvement in VSED,

55. Quill and Byock, "Responding to Intractable Terminal Suffering," 410.

56. Lynn A. Jansen, "No Safe Harbor: The Principle of Complicity and the Practice of Voluntary Stopping of Eating and Drinking," *Journal of Medicine and Philosophy* 29.1 (February 2004): 65, doi: 10.1076/jmep.29.1.61.30413.

57. Ibid., 66.

58. Lynn A. Jansen and Daniel P. Sulmasy, "Sedation, Alimentation, Hydration, and Equivocation: Careful Conversation about Care at the End of Life," *Annals of Internal Medicine* 136.11 (June 2002): 848, doi: 10.7326/0003-4819-136-11-200206040-00014.

59. Jansen, "No Safe Harbor," 69.

whether it be providing information about the practice or collaborating in providing palliative care while the patient is starving and dehydrating himself.

An Alternative to Complicity in VSED

Very little research has been done on the reasons why patients request VSED, as most of the studies have been devoted to physician-assisted suicide. One major danger concerning VSED is that the law does not require that the patient be evaluated for depression or any other mental health issues.[60] Because of this serious area of neglect, it is imperative that the physician involve the entire health care team to assess and address the patient's needs. The patient should be treated no differently than anyone else who expresses suicidal ideation. When a person is suicidal, society expects everyone around him to prevent him from harming himself. It is even more vital for the physician, whose role is to do no harm, to assure his patient's overall well-being instead of cooperating with his death wish.

Because of cost containment issues, doctors can only spend a limited amount of time with patients in the office or at the hospital. In a society that rewards efficiency, it is difficult for physicians to take the time to fully address patients' mental health needs. But when a patient requests VSED, a human life is at stake, and the patient needs to be listened to, cared about, and affirmed. The physician needs to carve out time to thoroughly address the factors that may be contributing to a patient's VSED request. Then instead of explaining to the patient what to expect from VSED if he chooses that option, the physician needs to refer the patient to a mental health professional for a full psychosocial and mental health assessment.

The increase in requests for VSED may be attributable to societal factors, such as a growing sense of isolation caused by our greater reliance on technology as the primary medium for communication, as well as the fact that geographical separation hinders families' ability to provide social support. The doctor must also be sure to address and alleviate physical pain that might be contributing to a patient's depression.

If a patient is very ill, mental health professionals can use a clinically relevant tool like the Patient Dignity Inventory for assessment. This kind of instrument would be helpful in revealing the underlying reasons that patients request VSED and helping caregivers respond effectively to them. The inventory consists of twenty-five statements that patients answer on a five-point scale, from "not a problem" (1) to "an overwhelming problem" (5). The statements include "feeling that I am a burden to others," "not feeling supported by my community or friends and family," "not being able to carry out tasks associated with daily living (e.g., washing myself, getting dressed)," "feeling that I am not making a meaningful and/or lasting contribution in my life," "feeling depressed," "not being able to carry out important roles (e.g., spouse, parent)," and "worrying about my future."[61] A truly compassionate response to the patient consists in addressing the issues that make him feel hopeless.

60. Byock, "Patient Refusal of Nutrition and Hydration," 10.

61. "The Patient Dignity Inventory," Dignity in Care, accessed January 27, 2017, http://www.dignityincare.ca/.

Because contemporary society emphasizes independence rather than interdependence, many people fear being a burden on others. Patients who require family caregiver support may request VSED to spare their relatives the stress that may come from providing hands-on care and from watching the patient's decline. Health care professionals can teach their patients to reframe this kind of thinking. Looked at from a different perspective, the patient's dependence gives the health care professionals and the community an opportunity to share and utilize their gifts to help others.

Recognizing how much more difficult it can be for some people to receive than to give, Wendy Lustbader, in her book, *Counting on Kindness*, speaks about how we can help those who are suffering understand that, far from being a burden, they are giving the people around them the gift of being able to give and to "transcend their own problems."[62] Michael Gloth affirms the same when he encourages patients to remember how they felt when they were able to serve someone in need.[63] He asks his patients whether they would want to deprive their family members of that good feeling. At the same time, professional and family caregivers need to let the patient know that they value his company and will be there for him in the good times and in the difficult times as well.[64]

Patients need to know that they matter and that their worth is not dependent on how they look, how much they contribute economically to society, or how much they are capable of performing physically or mentally. People need acknowledgment that, just by being, they are worthwhile. Just as they do not need to do anything to earn God's love, we need to impress on them that their value in our eyes does not depend on what they do for us.

62. Wendy Lustbader, *Counting on Kindness: The Dilemmas of Dependency* (New York: Free Press, 1991), 32.

63. F. Michael Gloth III, "Faith in Practice: End-of-Life Care and the Catholic Medical Professional," *Linacre Quarterly* 78.1 (Spring 2011): 77, doi: 10.1179/002436311803888500.

64. Arland K. Nichols, "Compassion and Love: The Antidote for Sentimentalism at the End of Life," *Linacre Quarterly* 80.4 (Winter 2013): 382–385, doi: 10.1179/2050854913Y.0000000009.