American Clinicians Academy on Medical Aid in Dying
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Ethics Consultation Service

Voluntary Stopping of Eating and Drinking and Medical Aid in Dying

January 3, 2023

CASE Number: 5
Date of request: October 16, 2022

Requestor: Physician who provides aid in dying.

Title: Voluntary Stopping of Eating and Drinking and Medical Aid in Dying

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Abstract: An ethics consultation request was placed by a physician who had a patient with a chronic but not terminal condition who requested to qualify for aid in dying by proceeding with voluntary stopping eating and drinking (VSED). The patient was experiencing unremitting suffering with chronic diarrhea following resection of colorectal cancer, which was cured, and therefore no longer had an incurable and irreversible illness. The patient reasoned that if he stopped eating and drinking, he would become terminal and thus qualify for medical aid in dying (MAID).

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I. Case Summary

The patient is a 72-year-old male who requested a evaluation for medical aid in dying for the diagnosis of "colon cancer," for which he underwent a total colectomy. Three years prior to his aid-in-dying request, the patient was found to have an adenocarcinoma of the colon in 2 of 6 polyps in the ascending and descending colon. One of the cancers had spread to the thick muscle of the colon, but not through to the serosal surface or beyond. Local excision of all lesions was performed, but post-op the patient developed necrotic bowel, leading to a complete colectomy with anastomosis of the distal ileum to the rectum. Nearby lymph nodes were negative for cancer. No chemotherapy or radiation were performed.

During the three post-op years before the patient's request for aid in dying, he showed no recurrence of cancers. However, he was quite ill from his colon surgery, mostly with severe spasmodic diarrhea after even small amounts of food: "I cannot tolerate solid food. I am extremely weak, dull-minded, and dizzy. My life for the last three years since the operations has consisted of moving between the bedroom and bathroom every fifteen minutes. I cannot leave my house." The patient had also developed severe macular degeneration, further limiting his activities of daily living. Continued progression to more-complete blindness was seen as inevitable.

As well, as a result of chronic abdominal pain, he had been prescribed significant doses of opioids and developed tolerance to the opioids and increasing pain. He had multiple consultations with gastroenterologists and bowel surgeons, all of whom recommended a colostomy to avoid his frequent diarrhea and stool-evacuation needs. He refused all additional surgeries, stating, "Look what happened to me from the first ones."

The patient is also followed by a palliative care physician, and claims no improvement in any of his activity-limiting diarrhea. The patient has been a registered nurse, now retired, and feels no financial limitations. He is fully insured by Medicare.

Pre-colon surgery weight: 210 lbs, present weight: 185 lbs, stable for the past year.

II. Ethics Question(s) as Described by Requester:

Does voluntary stopping of eating and drinking qualify a patient for medical aid in dying without an underlying disease with a less than 6-month prognosis?

III. Ethics Question(s) as Formulated by the Academy Ethics Consultation Service

Not withstanding its legality, is it ethically supportable for a clinician to provide aid in dying for a patient who does not have a underlying terminal diagnosis and has chosen to stop eating and drinking in order to qualify for medical aid in dying?

IV. Information Gathering

November 3, 2022: Initial meeting with requesting physician to discuss the details of the case. Summary: In addition to the information provided in the case summary, the additional information provided by the physician about the case included:

1. It was unknown what specific treatments were tried to manage the patient's diarrhea, but he was under the care of a very trusted palliative medicine physician.

2. The aid in dying physician had an extensive discussion with the patient regarding potential quality of life with an ileostomy in order to further explore the patient's refusal of this proposed surgery.

3. Regarding the patient's social support and history, he was married, and his wife was very supportive of his choices. They had no children.

4. Psychological history: The patient has no history of suicide attempts, significant suicidal ideology, nor major depression. He has no history of a substance abuse disorder. The patient fully acknowledges being depressed by his present circumstances. The patient stated that he had a gun in the house, but would never resort to using it to end his own life because it would be too traumatic for others. Social isolation in the end made his life intolerable to him.

5. Spiritual history: The patient was a Satanist. This request was consistent with his spiritual beliefs.

6. There was a hospice willing to admit the patient for purpose of voluntary stopping of eating and drinking.

November 16, 2022: Second meeting of the ethics consult team to deliberate this case. Summary of discussion:

1. The Academy Ethics Consultation Service member Jeanne Kerwin presented a case she was involved in in 2011 of a young woman who was quadriplegic from an accident who wanted to enroll in hospice in order to proceed with voluntary stopping of eating and drinking. There was significant resistance on the part of the hospice, and her symptoms were poorly managed. The team discussed the reasons hospices may be resistant to admitting patients who are not deemed terminally ill for the purpose of proceeding with stopping eating and drinking. This may have improved since 2011. The vital importance of better symptom management was discussed, including the ethical obligation to do so.

2. Thaddeus Pope discussed a case in Canada addressing qualifying for aid in dying via stopping eating and drinking — the Medical Board of British Columbia deemed this legal. This was in 2018.

3. Eligibility for hospice is similar to eligibility for aid in dying. Regarding hospice eligibility for stopping eating and drinking, Thaddeus Pope has participated in National Hospice and Palliative Care Organization (NHPCO) calls regarding stopping eating and drinking as the hospice qualifying diagnosis. There are hospices that will not enroll patients exclusively for voluntary stopping of eating and drinking. Others will enroll patients once stopping eating and drinking has started. Other hospices accept patients who are just planning to stop eating and drinking.

December 2, 2022: Third meeting of the ethics consult team. Summary of discussion:

1. All team members presented their perspective about this topic. There was not a consensus of opinion.

2. The team deliberated on whether voluntary stopping of eating and drinking qualifies as a terminal diagnosis, and at what point in the process. Would this qualify the patient according to legal definitions of terminal diagnosis in U.S. aid in dying laws?

December 30, 2022: Final meeting of the ethics consult team

V. Ethics Consultation Team Analysis:

1. This issue was considered from a legal as well as an ethical perspective, which should be separated and may well diverge.

> a. Legally, there is nothing in the letter of the law of any of the U.S. states' aid in dying bills that explicitly prohibits accepting voluntary stopping of eating and drinking as a terminal diagnosis to qualify for aid in dying. This remains a legal gray zone.
>
> b. Ethically, this practice could be supported for the same reasons aid in dying is allowed in other countries for non-terminally ill people, but it is certainly an extension of this practice as it currently exists in the U.S.

2. At what point does stopping eating and drinking become a terminal diagnosis, at the point of planning, after a specified period of time such as 24-48 hours, or at the point of organ failure? Should organ failure be the criteria? Would labs have to be checked in order to confirm this?

Once the patient is in irreversible organ failure (primarily kidneys) they are highly likely to develop delirium and lose decisional capacity. So when would the aid-in-dying process begin if the patient is not considered terminal early on when they have capacity?

3. Does it matter if the patient has an underlying progressive and eventually terminal condition or not? What about a patient who has unrelieved suffering but a non-progressive, non-terminal illness such as chronic severe but non-progressive pain? U.S. aid-in-dying laws do not include suffering as a qualification for aid in dying, just terminality.

4. If 95 out of 100 physicians would not prescribe aid in dying based on voluntary stopping of eating and drinking, can we ethically support the 5 out of 100 who would?

5. Voluntary stopping of eating and drinking is not an illness, it is a choice, and is reversible if the patient starts drinking and eating. At some point it does become a terminal condition with the onset of organ failure.

6. Non-terminally ill patients with decisional capacity have the ethical and legal right to choose to stop eating and drinking as an expression of their autonomy.

7. Offering aid in dying based on the patient's choice to proceed with stopping eating and drinking would represent a shift or expansion of the concept of terminal illness as a legally mandated qualifying criteria for medical aid in dying.

VI. Ethics Consultation Team Opinion

Although there were definitely areas of consensus, the consultation team did not reach a full consensus in their opinions on this issue.

There was consensus that regardless of what a patient chooses, the primary ethical duty is to offer to maximally relieve the patient's suffering to the extent possible.

Team members also agreed that while some clinicians would not offer aid in dying based on voluntary stopping of eating and drinking, there may be ethical justification to support those clinicians who would be willing to offer this, recognizing that this is a legal gray zone.

For team members who believe voluntary stopping of eating and drinking should not be a means to medical aid in dying, the conclusion is that while clinicians should do all they can to respect patients autonomous choices, there are limits to what can be offered.

Clinicians have a duty to practice according to the law, and to practice according to their own moral code as well. Opening access to aid in dying via stopping eating and drinking would essentially eliminate the criteria of terminal illness to qualify. They believe that the majority of clinicians would likely be unwilling to offer medical aid in dying to non-terminally ill patients in the U.S. Embarking on this could imperil the currently existing laws that allow access for terminally ill patients.

For team members who support allowing voluntary stopping of eating and drinking as a means to medical aid in dying, they conclude that under some circumstances, this may not violate U.S. state legal codes, and is ethically acceptable. They support the patient's autonomous choice to request this, with the intent of relieving suffering just as we do for terminally ill patients. This is an extension of the patient's right to self-determination.

VII. Ethically Supportable Recommendations:

1. Offering optimal palliation of suffering should always precede granting the patient's request for medical aid in dying or support for voluntary stopping of eating and drinking. Clinicians have an ethical duty to alleviate suffering based on the concepts of beneficence and nonmaleficence.

2. Use of stopping eating and drinking to qualify for aid in dying could be ethically supported in cases in which a patient has a progressive ultimately terminal illness with unrelieved suffering, but does not yet meet the < 6 month prognosis. This support would be based on respect for patient's right to self determination regarding when their suffering has become unbearable. It is debatable whether it is ethically supportable to qualify a patient for aid in dying using stopping eating and drinking without the presence of a progressive underlying illness. Clinicians should practice in accordance with the limits of the law as well as their professional and ethical principles.

3. From a legal perspective, we recognize that definitions of terminality vary in different jurisdictions allowing aid in dying. Consider seeking legal counsel within your state. There is no explicitly stated legal prohibition against using voluntary stopping of eating and drinking as a bridge to qualify for aid in dying, although the laws in place limit medical aid in dying to patients with terminal illnesses.

VIII. Confidentiality

All consultations are confidential. Complete documentation is recorded and protected internally by the Academy Ethics Consultation Service. Opinions and options presented are by consensus of consultation service members and do not represent their associated institutions.

IX. Disclaimers

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Submitted by Lynette Cederquist MD, Charles Miller MD (team leaders) for the American Clinicians Academy on Medical Aid in Dying Ethics Consultation Service.