The ethical and social implications of voluntary refusal of food and fluid (VRFF) in end-of-life care

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Living with illness has become a topic of debate, particularly in light of medicine’s ability to extend life. As euthanasia, or physician-assisted suicide, is illegal in the UK, some people wanting to die find an alternative, voluntary refusal of food and fluid (VRFF). However, such a method has not been well received either by law, doctors or even patient themselves. Thus, in this research, the legitimacy of VRFF and its implications for future policy making in terms of end-of-life care will be discussed.

 Definitions

End-of-life care aims to support those with advanced, progressive, incurable illness to live as well as possible until they die.¹

Voluntary refusal of food and fluid (VRFF) refers to a deliberate cessation of nutrition and hydration to hasten one’s death as s/he believes his/her life is low in quality and undignified.²

Euthanasia refers to a doctor, at the patient’s request, either providing the patient with the means to end the patient’s life (or if the patient is physically unable to do so) ending the patient’s life ‘to preserve patient autonomy and dignity’.³

Background Information

Alan Alberts (US)
Alan had suffered from Alzheimer’s disease for years. Due to his unwillingness to live through the last stage of Alzheimer’s disease, he and his wife decided to hasten his death by VRFF. During the nine-and-half day process, he was cared for by two caregivers and a doctor on a 24/7 basis. Moreover, fentanyl patches and liquid morphine to relieve his distress were administered. According to his wife, Alan was mentally competent during the whole process and ultimately passed away in peace.⁴

Tony Nicklinson (UK)
Tony suffered a catastrophic stroke during a business trip to Athens in 2005 and was left paralysed for the next 25 years due to ‘locked-in’ syndrome.⁵ Calling his life a ‘living nightmare’, he requested the court permit a doctor to offer him a lethal dose to end his life and to be free from the accusation of murder. As his case failed, he decided to take VRFF as an alternative and died after 6 days.⁶ There was no clear evidence of what kind of medical support Mr. Nicklinson received during his last couple of days.

Methodology

● A desk-based literature review of relevant sources was undertaken, using media reports and academic literature. The review focused on those individuals who were terminally ill and had expressed a wish to end their life.

● While this issue has been debated worldwide, two cases, one from the UK and the other from the US, were selected for a comparative analysis. Both patients died because of VRFF after considering euthanasia. Thus, how the legality of euthanasia can affect the VRFF process and, in the UK, how end-of-life care can compensate this effect in the legal framework will be explored.

Discussion

● The legality of VRFF, can be guaranteed by Article 8 of the European Convention on Human Rights (ECHR), the right to respect for one’s private and family life. Yet, whether the doctor will be accused of murder if they offer palliative sedation during a patients’ VRFF is unclear. In this case, such circumstances should be further clarified in both the law and end-of-life care policies, as palliative sedation is part of the general end-of-life care service in the UK.

● What constitutes a patients’ ‘best interest’ is controversial and no consensus has been reached amongst the legal and medical professions or amongst patients themselves. Although, in the UK, the patient can nominate a lasting power attorney (LPA) or a deputy to ensure their wishes are followed when they fall unconscious, advance directives (living wills) can be a more convincing proof for both the doctor and the court. Therefore, to reduce patients’ suffering in VRFF, advance directives can be routinised as a part of the end-of-life care to emphasise patients’ right to control their lives.