Issues with VSED (in Scotland).

Abstract

Voluntary Stopping Eating and Drinking (VSED) has been available for decades to those Scots who wish to end their lives, and for those who wish to accelerate a likely unpleasant death and intractable suffering due to any number of chronic morbidities. Ending one's own life is not illegal in Scotland, and Voluntary Stopping Eating & Drinking (VSED) specifically operates on the principles of autonomy and a right to refuse (any form of treatment, including sustenance). Proponents of VSED have argued that it can be a process without anxiety or suffering where appropriate palliative support is provided. It can be acknowledged that this has been true in some cases. It has also been the case that some deaths via VSED have been considerably more traumatic. However, the experience of VSED may still be shorter and less traumatic than the end of life that would have been experienced otherwise if various chronic conditions had carried on to their inevitable conclusion. In many states, including Scotland, in the absence of Assisted Dying, VSED is the main alternative for autonomously accelerating death that can involve medical support. The process has indeed been a 'useful last-resort option', not only for those expected to die within a specific period of time (let's say six months), but remains legally available to those who suffer conditions that are not imminently terminal. VSED is of particular interest as, in the absence of legalised assisted dying (AD), it remains the closest analog to AD for any individual seeking to end their life. There are however a number of issues that deserve examination within the Scottish context in terms of both perception and delivery.

Introduction

The Scottish government has observed that

> [i]n 2016/17 there were about 57,000 deaths in Scotland, a figure set to rise slightly to just over 60,000 by 2037. Around 75% of these people will have needs arising from living with deteriorating health for the years, months, or weeks before they die.[1]

Scotland has long been regarded as the 'sick man of Europe. Scotland appears to have the widest health inequalities in Western Europe[2], linked to inequality and

[1] Scottish Government (2018) Palliative and End-of-Life Care by Integration Authorities: advice note. https://www.gov.scot/publications/strategic-commissioning-palliative-end-life-care-integration-authorities/pages/5/

[2] Mercer SW, Blane D, Donaghy E, Henderson D, Lunan C, Sweeney K. Health inequalities, multimorbidity and primary care in Scotland. Future Healthc J. 2023 Nov;10(3):219-225. https://pmc.ncbi.nlm.nih.gov/articles/PMC10753226/

deprivation[3] [4] [5], an ageing population[6], and with many of these additional years spent with health problems, often multimorbidities[7] [8] [9]. Multimorbidity "is increasing in prevalence in Scotland. It has several negative outcomes including higher mortality, decreased quality-of-life, [and] decreased functional status"[10]. Multimorbidities are already present in under 65s within the population, the proportion of the Scottish population suffering from more than one health condition is on the increase and is more prevalent among disadvantaged groups"[11], with onset from the age of fifty in deprived areas[12]. Scots aged over 70 years are living with an average of three chronic health conditions[13]. Personal and family scenarios where an individual will wish to end their life - due to intractable suffering, or due to an experience of 'social death' where their health has removed any sense of autonomy or social experience that could make life feel it is worth living - will likely increase in the years to come. In such cases, palliative care will continue to be insufficient for, and/or unpalatable to, some chronic sufferers[14] [15]. The position of a majority of British medical institutions

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[3] Scottish Government. Health and Social Care Strategy, as above. 2022.

[4] Cezard, G., Sullivan, F. & Keenan, K. Understanding multimorbidity trajectories in Scotland using sequence analysis. *Sci Rep* **12**, 16485 (2022). https://doi.org/10.1038/s41598-022-20546-4

[5] Miall, N; Fergie, G; Pearce, A. Health Inequalities in Scotland:trends in deaths, health and wellbeing, health behaviours, and health services since 2000. University of Glasgow. November 2022: 139. https://eprints.gla.ac.uk/282637/1/282637.pdf

[6] Government Office for Science. Future of an Ageing Population. 2016 .https://assets.publishing.service.gov.uk/media/5d273adce5274a5862768ff9/future-of-an-ageing-population.pdf

[7] Gondek et al (2021) Prevalence and early-life determinants of mid-life multimorbidity: evidence from the 1970 British birth cohort. BMC Public Health volume 21, Article number:1319. https://doi.org/10.1186/s12889-021-11291-w

[8] Healthcare Improvement Scotland: More about multimorbidity and diabetes. https://rightdecisions.scot.nhs.uk/type-2-diabetes-mellitus-quality-prescribing-strategy-a-guide-for-improvement/polypharmacy-in-diabetes/more-about-multimorbidity-and-diabetes/

[9] Mercer, Stuart Prof. Multimorbidity. Advanced are Research Centre. https://edwebcontent.ed.ac.uk/sites/default/files/atoms/files/acrc_briefing_3_v.1.pdf

[10] ADRUK. Multimorbidity and the use of health and social care. https://www.adruk.org/our-work/browse-all-projects/multimorbidity-and-the-use-of-health-and-social-care-71/

[11] Miall et al. ,Health Inequalities in Scotland:2022: 139, as above.

[12] Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. Lancet. 2012 Jul 7;380(9836):37-43. https://pubmed.ncbi.nlm.nih.gov/22579043/

[13] Scottish Government. Health and Social Care Strategy for Older People: Analysis of Consultation Responses, 2022. https://www.gov.scot/publications/health-social-care-strategy-older-people-analysis-consultation-responses/

[14] Cookson et al. Unrelieved Pain in Palliative Care in England. National Institute for Health Research. 2019 https://www.ohe.org/publications/unrelieved-pain-palliative-care-england

[15] Riley, L & Hehir D. The Inescapable Truth About Dying in Scotland. Study conducted by the Office of Health Economics for Dignity in Dying. 2019 https://www.dignityindyingscotland.org.uk/wp-content/uploads/sites/2/2025/02/DiD_Inescapable_Truth_Scotland_WEB.pdf

on assisted dying (AD) has currently settled at neutral[16], although a recent attempt to legislate on the subject in Holyrood failed. Assisted Dying, as it is understood in the McArthur Assisted Dying For Terminally Ill Adults (Scotland) Bill (2024), remains without formal legislation in Scotland. Nonetheless, Scots seeking to accelerate their death can implement a range of options. There are a number of practices extant in Scotland that lead to an accelerated death, each with it's own issues[17]:

- palliative support only - which may prove undesirable to some individuals, or incapable of sufficiently ameliorating suffering in some cases;
- suicide attempt - not illegal in Scotland, but lone attempts may be traumatic and/or unsuccessful;
- suicide with 'amateur' assistance (not assisted and monitored by a medical professional) - unlikely to lead to a prosecution or a custodial sentence under certain circumstances;
- Dignitas or a similar foreign facility - highly unlikely to lead to any legal action; denial or withdrawal of treatment and sustenance by medical staff;
- double effect - common within end-of-life treatment, regarded by some as a form of indirect euthanasia;
- heavy dosage drug administration short of inducing unconsciousness - common within end-of-life treatment;
- heavy dosage drug administration involving induced unconsciousness (Continuous Deep Sedation (CDS)) - common within end-of-life treatment); and
- Voluntary Stopping of Eating and Drinking (VSED). It is this latter process, often accompanied by administration of drugs by medical practitioners, that is the focus of this document.

There is no legal ambiguity in relation to the assistance and support provided by Scottish medical staff for individuals who have opted for VSED, despite VSED being possibly the closest analog to assisted dying. Unlike 'double effect' where at least lip-service can be paid to the claim of death being 'foreseen but not intended', death is understood explicitly to be both foreseen AND intended in VSED. Within the context of an increasing number of Scots likely to experience conditions which can lead to a desire to end their lives, and in view of the continuing lack of legislation to enable AD, it is worth examining VSED.

Voluntary Stopping Eating and Drinking - the consensus

Also known as Voluntary Refusal of Food and Fluids (VRFF), this is a process which often involves medical staff (although it can also be carried out and supported independently) where an individual can end their life. Voluntary stopping of eating

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[16] Robertson, J. Legal Rulings, Legislation and Social Change in Scotland Relating to Assisted Dying.2026: 19-21. https://www.academia.edu/166289694/Legal_Rulings_Legislation_and_Social_Change_in_Scotland_Relating_to_Assisted_Dying

[17] Robertson, J. Legal Rulings 2026: 32-38, as above.

and drinking is an end-of-life choice that is available in many states where assisted dying remains illegal.

Pope & Anderson argue that "VSED is a method of hastening death that dates back thousands of years".[18] Ivanović et al concur with the perception that VSED is a peaceful process, describing it as a process that stops poor quality of living and greater suffering where "palliation or symptom management is ineffective and cannot relieve discomfort"[19] and offers the patient a greater feeling of autonomy, (although the length of time take to die can be a disadvantage). According to Wechkin et al:

> VSED is a deliberate, self-initiated action by a patient with decision-making capacity (DMC) to hasten death in the setting of suffering refractory to optimal palliative interventions, prolonged dying that the person finds intolerable, or expected deterioration or suffering due to an irreversible illness, that the person regards as unacceptable. This action is typically undertaken by a patient with a serious illness associated with a life expectancy of months or years. VSED is characterized by the exercise of a specific choice at a specific time and is dependent on the patient having sufficient decisional capacity at the time that VSED is initiated.[20]

According to Wax et al,

> Individuals who consider VSED tend to be older, have a serious but not always imminently terminal illness, place a high value on independence, and have significant illness burden.[21]

In terms of incidence, there appear to be no Scottish records, although studies from Japan and Oregon cited by Lowers et al suggest that between 32-41% of hospice palliative physicians and hospice nurses had experience of VSED.[22] Bolt et al found in that in their survey of over 700 physicians between October 2011 and June 2012 in the Netherlands, "46% had cared for a patient who hastened death by VSED".[23] In

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[18] Pope, Thaddeus & Anderson, Lindsey. Voluntarily Stopping Eating and Drinking: A Legal Treatment Option at the End of Life. Widener Law Review, Vol 17. 2011: 388. https://www.researchgate.net/publication/47354408_Voluntarily_Stopping_Eating_and_Drinking_A_Legal_Treatment_Option_at_the_End_of_Life

[19] Ivanović, N., Büche, D. & Fringer, A. 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 Palliat Care* **13**, 1 (2014). https://doi.org/10.1186/1472-684X-13-1

[20] Wechkin H et al. Clinical Guidelines for Voluntarily Stopping Eating and Drinking (VSED) Journal of Pain and Symptom Management, 2023; 66, e625-e631 https://www.jpsmjournal.com/article/S0885-3924(23)00565-1/fulltext

[21] John W. Wax MD, Amy W. An MD, Nicole Kosier MD, Timothy E. Quill MD. Voluntary Stopping Eating and Drinking. Journal of American Geriatrics Society, Volume66, Issue3 March 2018, Pages 441-445. https://agsjournals.onlinelibrary.wiley.com/doi/full/10.1111/jgs.15200

[22] Lowers, J et al. Overview of voluntarily stopping eating and drinking to hasten death. Annals of Palliative Medicine. Vol 10, No 3, March 31, 2021. https://apm.amegroups.org/article/view/44492/html

[23] Bolt EE, Hagens M, Willems D, Onwuteaka-Philipsen BD. Primary care patients hastening death by voluntarily stopping eating and drinking. Ann Fam Med. 2015 Sep;13(5):421-8. doi: 10.1370/afm.1814. PMID: 26371262; PMCID: PMC4569449.

their literature review, Mensger et al found that "surveys from different countries have shown that 32%–62% of participating healthcare professionals had already accompanied a person during VSED".[24] Bolt et al subsequently detail in 2023 that "[s]tudies showed that 46% of Dutch general practitioners (GPs) and 43% of Swiss GPs provide care to patients during VSED in their career. In Oregon, 41% of hospice nurses have experience with VSED. Studies from the Netherlands and Switzerland estimated 0.5% to 2.1% of people who die do so by VSED."[25] Accurate estimates of numbers remains problematic, as details of cause of death can vary on death-certificates, and as Bolt et al note "[s]ome patients do not involve others in VSED."[26]

The right to refuse food or hydration in Scotland predates *Law Hospital NHS Trust v Lord Advocate* 1996 SC 301[27], but the case result may be the first time the Scottish courts had made this explicit:

> It is not in doubt that a medical practitioner who acts or omits to act with the consent of his patient requires no sanction or other authority from the court. The patient's consent renders lawful that which would otherwise be unlawful. It is not for the court to substitute its own views as to what may or may not be in the patient's best interests for the decision of the patient, if of full age and capacity.[28]

In England and Wales, the outcomes of NHS Trust v. Y, and Briggs v. Briggs, supported the permissibility of withdrawing constant artificial nutrition and hydration, (as the Law Hospital Trust case did in Scotland). The Supreme Court in relation to the ruling on R (Nicklinson) v Ministry of Justice[29], subsequently clarified that mentally competent adults can refuse food and water, and that medical staff should comply with such requests and can manage any resulting discomfort without fear of prosecution.

There is an overall lack of research and data on the subject of VSED in Scotland (and in general), and a lack of consensus on VSED and the potential issues therein. Death is the intended result from the process as a whole. The contribution of the dosage to either effective pain-control or indeed overall cause of death remains open to debate. The purpose of VSED, as supported and understood by Scottish medical staff, is for the individual to end their life, an outcome that is both foreseen and

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[24] Christina Mensger, Yang Jiao, Maximiliane Jansky, Christian Banse, Friedemann Nauck, Monika Nothacker, Henrikje Stanze. Voluntarily stopping eating and drinking (VSED): A systematic mixed-methods review focusing on the carers' experiences. Health Policy Volume 150, December 2024, 105174. https://www.sciencedirect.com/science/article/pii/S0168851024001842 27/04/25

[25] Bolt EA, Pasman HR, & Onwuteaka-Philipsen BD. Patients Who Seek to Hasten Death by Voluntarily Stopping Eating and Drinking: A Qualitative Study. The Annals of Family Medicine November, 21 (6) 534-544; 2023:534. https://www.annfammed.org/content/21/6/534

[26] Bolt et al. Patients who seek, 2023:534, as above.

[27] Robertson 35-36

[28] Law Hospital NHS Trust v Lord Advocate SC 301 1996 paragraph 1, The Function of the Court. https://www.bailii.org/scot/cases/ScotCS/1996/1996_SC_301.html

[29] R (Nicklinson) v Ministry of Justice [2014] UKSC 38, para 255, http://www.bailii.org/uk/cases/UKSC/2014/38.html

intended. As Quill et al confirm "[d]eath is definitely intended with VSED"[30], clarifying that '[i]n suicide a person intentionally aims at her own death and directly causes it; in a typical VSED, too, a person intends to die and directly causes the death. As a matter of descriptive fact, then, VSED is a form of suicide."[31] Loewy refers to "physician stimulated starvation"[32] as a key phrase related to VSED. In their guidance on treatment related to VSED, the Royal Dutch Medical Association note that:

> Some authors consider VSED to be (a specific form of) suicide (Van den Brink 2015, Den Hartogh 2014 and 2023, Jox 2017, Lachman 2015, Menzel 2022, McGee 2017, Quill 2015-1, Schneider 2021), other authors see essential differences between VSED and suicide (Pope 2011, Schmidhuber 2019) and yet other authors indicate that it depends on the circumstances (Jansen 2015, Moskop 2021, Schneider 2021).[33]

The process is not restricted to terminal patients, and is supported by the principle of a "right to refuse" any intervention. It is commonly carried out in conjunction with deep/terminal sedation and continuous care provided by medical staff. It is generally accepted within palliative care that medical involvement in Voluntary Stopping Eating and Drinking remains at 'arms-length', thereby removing any direct causality in the death of a consenting and competent individual who is seeking to end their own life. Supporters may argue that while a degree of facilitation exists, this is not analogous to causality.

Most commonly, VSED in Scotland is supported by medical staff, and is often carried out in conjunction at some point with some form of sedation. In some cases, the patient can be placed into induced unconsciousness which continues until death. It can be argued that although the level of sedation is potentially lethal as the body weakens from starvation and dehydration, death is foreseeable but not intended (the doctrine of double-effect) by the provision and maintenance of the dosage.

VSED is practiced within Scottish palliative care as a best available option where a patient seeks to end their life. It is most commonly performed while medical staff monitor the patient and provide care, supporting the patient where a patient has chosen to remain conscious by administering sedation where it is perceived to be needed, or in many cases inducing unconsciousness where the patient has chosen that

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[30] Quill, Timothy E.; Menzel, Paul T.; Pope, Thaddeus; Schwarz, Judith K.. Voluntarily Stopping Eating and Drinking: A Compassionate, Widely-Available Option for Hastening Death. Kindle Edition. Oxford University Press 2021: 34

[31] Quill, Timothy E.; Menzel, Paul T.; Pope, Thaddeus; Schwarz, Judith K.. Voluntarily Stopping Eating and Drinking: A Compassionate, Widely-Available Option for Hastening Death. Kindle Edition. Oxford University Press 2021: 67

[32] Loewy, E. "Euthanasia, Physician Assisted Suicide and Other Methods of Helping Along Death." Health Care Analysis, Springer Nature, 2004: 181. https://www.academia.edu/113873484/Euthanasia_Physician_Assisted_Suicide_and_Other_Methods_of_Helping_Along_Death?email_work_card=view-paper

[33] Royal Dutch Medical Association (KNMG). Guide: Caring for people who stop eating and drinking to hasten the end of life. December 14th, 2024: 29. https://www.knmg.nl/download/guide-caring-for-people-who-stop-eating-and-drinking-to-hasten-the-end-of-life

option. The patient will starve and dehydrate to death with the cause of death often reported as cardiac arrhythmia.

A key assumption has been that the process occurs over a short period, with any discomfort ameliorated by palliative care. This remains a convenient assumption. The extensive lack of studies to establish just how smooth, or otherwise, the process is for individuals remains an issue of concern. Certainly, reports by those involved with VSED while the individual remains conscious include details of a range of discomforts experienced. As for those placed into induced unconsciousness, conventional but untested thinking has been that unconscious individuals will not experience discomfort, but this may be an aspiration rather than a tested and proven claim.

Another question raised is why it would be any less subject to malfeasance i.e. coercion and targeting of vulnerable individuals that opponents of assisted dying claim would be part and parcel of state-supported processes to assist individuals to end their lives. It is, after all state-supported and has been accessible for some time, and without the extensive protections advanced by the McArthur Bill. It can be noted that opponents of AD do not appear to have committed similar time, attention and resources to the protection of individuals pursuing VSED. VSED has been available, legal and accessed by Scots for decades. It is supported by the national health service and in private care homes. VSED merits an examination both as a counterpoint to assisted dying and in its own right.

There are several potential problems with VSED:

1. The problem of VSED's similarity to Assisted Dying.
2. The problem of lack of data.
3. The problem of a lack of standardised national guidance, and potential inequality of provision.
4. The problem of no standardised protections against malfeasance.
5. The problem of suffering.

1. The problem of VSED's similarity to Assisted Dying

As detailed earlier, there has been a strong consensus amongst many that providing palliative care for VSED patients is a medical response to suffering, but does not assist in the intended death. Pope[34] argues that there are key differences that differentiate palliative care in the context of VSED, as the level of active medical support simply does not qualify it as an assisted suicide. Unlike an assisted death, any medical support provided in VSED is argued to be very specifically an act of care. Providing and even administering drugs to alleviate suffering within the VSED process, even where the level of dosage may cause death, is regarded as within the

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[34] Pope, T.M. Voluntarily stopping eating and drinking (VSED) to hasten death: may clinicians legally support patients to VSED?. *BMC Med* **15**, 187 (2017). https://doi.org/10.1186/s12916-017-0951-0

'doctrine of double-effect' where death is foreseeable but not intended. Lowers et al note that Dutch clinicians are advised that VSED is not "equivalent to suicide because the latter is associated "with an active, violent, lonely, and often impulsive act"'[35], although this would appear to be a limited view of suicide. However, VSED is indeed not the result of an invasive or aggressive act, thereby skirting a legal interpretation of causality, much as forms of AD do where a lethal substance is self-administered. The only difference here is between taking a single pill and dying relatively quickly and taking nothing and dying relatively more slowly. The intent and outcome can and have been argued to be the same.

While Jox et al define VSED as the intention and act of causing the shortening and ending a life, they suggest that "VSED is a form of suicide by omission – the person's omission of eating and drinking directly causes death"[36], McGee & Miller argue that "even if VSED is classified as a kind of suicide, physician involvement in VSED is not a form of assisted suicide."[37] Pope & Anderson argue that in VSED medics simply respect the wishes of the patient, and that

> VSED is not assisted suicide as it "entails a passive refusal. The patient's natural state is to dehydrate unless fluids are affirmatively introduced. VSED does not entail the acceleration of this process, but rather the mere absence of action to slow or stop it.[38]

Pinho-Reis & Capelas argue that "healthcare professionals who provide palliative care for patients undergoing VSED cannot be regarded as agents of these patients' deaths, unless they do something to accelerate death".[39]Mentzel et al argue that "[a]lthough the outcome is both predictable and expected, the palliative care worker is not complicit, merely prioritising his or her duty of care as far as the law will allow"[40] and that "[i]n cases where a condition is terminal, it can be seen not as facilitating suicide but as facilitating a better death."[41] Lock & O'Neill support this view, arguing that:

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[35] Lowers et al. Overview of voluntarily stopping eating and drinking, 2021 as above.

[36] Jox, Ralf J, Black, Isra orcid.org/0000-0001-5324-7988, Borasio, Gian Domenico et al. (1 more author) (2017) Voluntary stopping of eating and drinking: is medical support ethically justified? BMC Medicine. 186. ISSN 1741-7015 https://doi.org/10.1186/s12916-017-0950-1

[37] McGee A, Miller FG. Advice and care for patients who die by voluntarily stopping eating and drinking is not assisted suicide. BMC Med. 2017 Dec 27;15(1):222. doi: 10.1186/s12916-017-0994-2. PMID: 29282122; PMCID: PMC5745593. https://pmc.ncbi.nlm.nih.gov/articles/PMC5745593/

[38] Pope, Thaddeus & Anderson, Lindsey. Voluntarily Stopping Eating and Drinking: A Legal Treatment Option at the End of Life. Widener Law Review, Vol 17. 2011: 420-21. https://www.researchgate.net/publication/47354408_Voluntarily_Stopping_Eating_and_Drinking_A_Legal_Treatment_Option_at_the_End_of_Life

[39] Pinho-Reis & Capelas M. Refusal of Oral Feeding and Nutrition 2025: 10 as above.

[40] Mentzel, PT. Ethical Issues, chapter in Quill, TE et al Eds. Voluntary Stopping Eating and Drinking: A Compassionate, Widely Available Option for Hastening Death. 71 https://www.google.co.uk/books/edition/_/Q30_EAAAQBAJ?hl=en&gbpv=1&pg=PA60&dq=VSED+coercion

[41] Mentzel, PT. Ethical Issues: 73, as above.

> "[e]thically it is not necessary for healthcare professionals to share the patient's intention of hastening their death to provide clinical care, hence they should not be considered complicit or instrumental to a patient's deterioration through VSED……Declining to admit such patients to a hospice on the basis that this may constitute assisting suicide risks leaving them vulnerable to suboptimal symptom control and merely displaces ethical discomfort onto an alternative group of healthcare professionals."[42]

McGee & Miller reiterate that "an essential goal of medicine is to relieve suffering and physicians do no wrong when offering standard medication to relieve the suffering ensued by patients exercising their own autonomous choice".[43] Pinho-Reis & Capelas argue that:

> For the past decades VSED has been more discussed as one possibility among several to preserve autonomy, to maintain control and to hasten death without infringing the bioethical principles of beneficence, nonmaleficence, justice, vulnerability, and autonomy.[44]

An argument can be made that 'double effect' applies and that medical staff are simply tending to the comfort of an individual who is dying by their own hand, and that any drugs administered are purely to soothe discomfort, and that any contribution of drugs administered is intended to be purely palliative. Quill et al note that:

> [i]n a 2015 guidance document, the GMC advises that no prohibition prevents a doctor from "agreeing in advance to palliate the pain and discomfort involved for such a patient should the need arise for such symptom management" (General Medical Council 2015). The GMC subsequently confirmed that symptom management includes the symptoms which arise from VSED which progresses to that individual's death. "Doctors may agree with their patients in advance to provide medicines or treatment to alleviate pain or other distressing symptoms, should the need arise" (General Medical Council 2018). Notably, there have been many high-profile VSED deaths in the UK, yet no liability or sanctions (Culzac 2014; Savulescu 2014).[45]

Quill & Byock note:

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[42] Lock H, O'Neill C. 75 Should hospices provide inpatient care to patients voluntarily stopping eating and drinking with intent to hasten death? An ethical argument to support patient autonomy whilst acknowledging professional discomfort BMJ Supportive & Palliative Care 2023;13:A36. https://spcare.bmj.com/content/13/Suppl_3/A36.1.citation-tools

[43] McGee & Miller. Advice and care for patients 2017 as above.

[44] Pinho-Reis C, Luís Capelas M. Refusal of Oral Feeding and Nutrition or a Way to Speed Up Dying Without Asking Permission: Voluntarily Stopping of Eating and Drinking in the End of Life. Revista Iberoamericana de Bioética / nº 27 / 01-15 [2025] [ISSN 2529-9573] 2025: 3. https://ciencia.ucp.pt/ws/portalfiles/portal/126213589/114301666.pdf

[45] Quill, Timothy E.; Menzel, Paul T.; Pope, Thaddeus; Schwarz, Judith K.. Voluntarily Stopping Eating and Drinking: A Compassionate, Widely-Available Option for Hastening Death. Kindle Edition. Oxford University Press 2021: 90-91

> When unacceptable suffering persists despite standard palliative measures, terminal sedation and voluntary refusal of food and fluids are imperfect but useful last-resort options that can be openly pursued.[46]

There are however some counter-arguments.

AD is intended as a process to curtail unnecessary suffering and to provide a painless end of life. VSED has been regarded by some as a close analog as both processes involve medical support, and for both processes an accelerated death is the expected and intended outcome. As Rama et al note, VSED has gained attention "particularly in contexts where other forms of physician-assisted dying (PAD) or euthanasia are not legally available or are ethically controversial."[47]

VSED exists on the edge of double effect, where any death occurring as a result of overdose is argued to have been "foreseen but not intended". Bhyan et al argue that "[p]alliative sedation intends to relieve refractory symptoms in dying patients, whereas the intention of physician-assisted suicide and euthanasia is the termination of a patient's life."[48]However, they also note that "[t]he use of palliative sedation continues to be a controversial topic, given that its use can potentially hasten death."[49] As a person undergoing VSED weakens and organs fail, and particularly in the cases where induced unconsciousness is involved, death linked to overdose due to palliative sedation cannot be discounted.

Jox et al argue that "VSED is a form of suicide by omission - the person's omission of eating and drinking directly causes death,"[50] and the hastening of the ending one's life is the clear intention. No medical staff providing support will be in any doubt about that. The perceived difference may come down to notions of causality. The line between facilitation and assistance may be argued to be rather thin. A great deal has been taken on faith in the absence of research, in relation to VSED, simply because it has allowed the medical community to maintain a veneer of passivity within that process. Medical practitioners themselves experience ambiguity

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[46] Quill, TE. & Byock, IR. Responding to Intractable Terminal Suffering: The Role of Terminal Sedation and Voluntary Refusal of Food and Fluids. Annals of Internal Medicine. Volume 132. Number 5. March 2000. https://www.acponline.org/sites/default/files/documents/clinical_information/resources/end_of_life_care/intractable_suffering.pdf

[47] Rama SA, Alonso A. Sanchez A, Kashan S. Voluntary Cessation of Eating and Drinking: Asserting the Right to Choose. Journal of Pain and Symptom Management Volume 71, Issue 6, June 2026: e1226-e1227. https://www.jpsmjournal.com/article/S0885-3924(26)00730-X/pdf

[48] Bhyan P, Shrestha U, Schoo C, Goyal A. Palliative Sedation in Patients With Terminal Illness. National Library of Medicine, 2026. https://www.ncbi.nlm.nih.gov/books/NBK470545/

[49] Bhyan P, Shrestha U, Schoo C, Goyal A. Palliative Sedation in Patients With Terminal Illness. National Library of Medicine, 2026. https://www.ncbi.nlm.nih.gov/books/NBK470545/

[50] Jox, Ralf J, Black, Isra, Borasio, Gian Domenico et al. Voluntary stopping of eating and drinking: is medical support ethically justified? BMC Medicine. 186. 2017

in terms of difference between VSED and AD[51]. Jox et al argue that there is inconsistency in the support of palliative care societies, professional bodies of physicians, legal scholars, and ethicists:

> Most Western jurisdictions seem to permit medical support for VSED, even in jurisdictions where assisted dying is prohibited by law.… the widely held position by palliative care societies, professional bodies of physicians, legal scholars, and ethicists to disapprove of assisted suicide but approve of and even promote medically supported VSED appears inconsistent.[52]

Liu et al[53] contend that there are three types of 'Deep and Continuous Palliative Sedation without Artificial Nutrition and Hydration'. Type 1 is palliative sedation that will not hasten the patient's death. Type 2 might, but is not certain to, hasten death, as in the doctrine of double-effect. Type 3 is certain to hasten death. They note that all three types are practiced in Australia, Colombia, the Netherlands, Switzerland, the United States of America. The first two exist within palliative care provision in Scotland as, arguably, may the third.

Liu et al[54] note that Type 3 is perceived as a form of euthanasia or assisted dying in a number of states. Liu et al acknowledge the risk that "there could be a situation where Type 3 Deep and Continuous Palliative Sedation without Artificial Nutrition and Hydration is allowed in the absence of the safeguards usually associated with euthanasia."[55] Jox et al argue that:

> VSED falls within the concept of suicide, albeit with certain unique features (non-invasiveness, initial reversibility, resemblance to the natural dying process). Second, we demonstrate, on the basis of paradigmatic clinical cases, that medically supported VSED is, at least in some instances, tantamount to assisted suicide. This is especially the case if a patient's choice of VSED depends on the physician's assurance to provide medical support.[56]

They go on to argue that:

> Two elements of assistance in suicide are critical for our argumentation. First, the assistance is instrumental for death to occur, meaning that, without the assistance, the suicide would not (or could not) occur. Second, the assisting

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[51] Gerson, S.M., Bingley, A., Preston, N. et al. When is hastened death considered suicide? A systematically conducted literature review about palliative care professionals' experiences where assisted dying is legal. BMC Palliat Care 18, 75 (2019). https://doi.org/10.1186/s12904-019-0451-4 https://doi.org/10.1186/s12904-019-0451-4

[52] Jox et al. When is hastened death considered suicide? 2019, as above.

[53] Liu, Richard, Pope, Thaddeus Mason and and Xu, April, Deep and Continuous Palliative Sedation without Artificial Nutrition and Hydration: An International Review (September 14, 2024). 35 Indiana International & Comparative Law Review XXX (forthcoming 2025)., 35(1) Indiana International & Comparative Law Review 67-151 (2025), Available at SSRN: https://ssrn.com/abstract=4956660 or http://dx.doi.org/10.2139/ssrn.4956660 https://open.mitchellhamline.edu/cgi/viewcontent.cgi?article=1622&context=facsch 27/04/25

[54] Liu et al. Deep and Continuous Palliative Sedation, 2024, as above.

[55] Liu et al. Deep and Continuous Palliative Sedation, 2024, as above.

[56] Jox et al. When is hastened death considered suicide? 2019, as above.

person knows and at least partially shares the patient's intention to induce death.[57]

In 2019 the BMA published updated guidelines[58] on responding to patient requests for assisted dying, despite it remaining illegal. The guidance recognised the likelihood of continuous sedation contributing to death in patients who are starving themselves, as it may "when combined with a refusal of food and fluids, be construed as indistinguishable from assisted suicide."[59]

2. The problem of lack of data

While VSED has always been legal in Scotland, there is a definite lacuna in general in research into VSED. The number of VSED cases per year in Scotland is unavailable, although research noted earlier suggests a more common occurrence than some believe. Lowers et al suggest that "VSED may be more common than physician-assisted forms of dying simply because it falls beneath the level of legal scrutiny except in some cases involving institutional settings."[60] The Scottish Partnership for Palliative Care however note that "there are no systematic mechanisms in place to measure and understand the experiences and outcomes of people dying in Scotland".[61]

There is no formal regulatory body for VSED, monitoring and reviewing data and reporting upon uptake numbers, practice and compliance. In general "such deaths are not even usually recorded as suicides".[62] [63] Quill et al note that "[l]ittle information is available in the published literature on the experience of patients wishing to VSED in institutional LTC [long-term care] settings"[64] and it is reasonable to assume that significantly less (if any) significant data exists in relation to non-institutional settings. VSED has none of the standardised recording processes or indeed

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[57] Jox et al. When is hastened death considered suicide? 2019, as above.

[58] British Medical Association. *Responding to patient requests for assisted dying: guidance for doctors*. 2019. https://www.bma.org.uk/media/1424/bma-guidance-on-responding-to-patient-requests-for-assisted-dying-for-doctors.pdf

[59] British Medical Association. *Responding to 2019, as above*.

[60] Lowers et al. Overview of voluntarily stopping eating and drinking to hasten death. Annals of Palliative Medicine. Vol 10, No 3 (March 31, 2021) https://apm.amegroups.org/article/view/44492/html#B24

[61] Scottish Partnership for Palliative Care (SPPC). Response to Proposals for an Assisted Dying for Terminally Ill Adults (Scotland) Bill. https://www.palliativecarescotland.org.uk/content/publications/SPPC-Response-to-Proposals-for-an-Assisted-Dying-Bill.pdf

[62] Nancy Preston, Sheila Payne, and Suzanne Ost. Breaching the stalemate on assisted dying: it's time to move beyond a medicalised approach BMJ 2023; 382 doi: https://doi.org/10.1136/bmj.p1968 (Published 29 August 2023)
Cite this as: BMJ 2023;382:p1968
27/04/25

[63] Uemura T, et al. Challenges in Completing a Death Certificate After Voluntary Stopping of Eating and Drinking [published online: July 27, 2023]. J Am Med Dir Assoc. DOI: https://doi.org/10.1016/j.jamda.2023.06.022.

[64] Quill, Timothy E.; Menzel, Paul T.; Pope, Thaddeus; Schwarz, Judith K.. Voluntarily Stopping Eating and Drinking: A Compassionate, Widely-Available Option for Hastening Death. Kindle Edition. Oxford University Press 2021: 111

protections[65] that the McArthur Bill proposed. As Ivanović et al conclude, "VSED has hardly been examined in the past 20 years."[66] The authors note that "[t]he available articles can indeed be described as heterogeneous and inconclusive. They represent a patchwork rather than a picture",[67] and offer "marginal insight into VSED for hastening death".[68] The authors also conclude that "[n]o study was found that explicitly examined physiological processes during VSED in adults at the end of life"[69] and and "[t]o date no qualitative study has comprehensively investigated patients' experiences with VSED at the end of life."[70]

Pope &West confirm that VSED has been under-examined compared to other end-of-life options[71], while Lowers et al confirm that "[t]o date there has been little published research on VSED".[72] Fringer and Staengle describe VSED as "a critical but poorly understood issue".[73] Without sufficient research it remains impossible to confirm that VSED deaths are as peaceful as some would claim, or for example whether coercion has been a genuine issue. Bolt et al note that

> "[t]he literature mostly comprises commentaries and case reports rather than original research…..They mention possible serious complications, such as a prolonged dying phase, thirst or hunger, agitation, delirium, and overburdened family members".[74]

Lowers et al found that "[f]ew studies have looked specifically at the incidence of VSED."[75] Pope et al confirm that "deep and continuous palliative sedation combined

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[65] Robertson, J. Legal Rulings 2026: 12-15, as above.

[66] N. Ivanovic, D. Bueche, and A. 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 theEnd of Life," BMC Palliative Care 13, no. 1 (2014).

[67] Ivanovic et al. Voluntary Stopping of Eating 2014, as above.

[68] Ivanovic et al. Voluntary Stopping of Eating 2014, as above.

[69] Ivanovic et al. Voluntary Stopping of Eating 2014, as above.

[70] Ivanovic et al. Voluntary Stopping of Eating 2014, as above.

[71] Pope, TM & West, A. Legal Briefing: Voluntarily Stopping Eating and Drinking. The Journal of Clinical Ethics 25, no. 1 (Spring 2014): 68-80. https://www.researchgate.net/publication/261996427_Legal_briefing_Voluntarily_stopping_eating_and_drinking

[72] Lowers et al. Overview of Stopping Eating, 2021, as above.

[73] Fringer, André and Stängle, Sabrina. Scientia, Nov 11, 2020 Editor's Pick, Medical & Health Sciences https://digitalcollection.zhaw.ch/server/api/core/bitstreams/0c46ed58-fe59-4e8c-a073-f5736cb68321/content 28/04/25

[74] Bolt EE, Hagens M, Willems D, Onwuteaka-Philipsen BD. Primary care patients hastening death by voluntarily stopping eating and drinking. Ann Fam Med. 2015 Sep;13(5):421-8. doi: 10.1370/afm.1814. PMID: 26371262; PMCID: PMC4569449.

[75] Jane Lowers, Sean Hughes, Nancy J. Preston. Overview of voluntarily stopping eating and drinking to hasten death. Annals of Palliative Medicine, Vol 10, No 3 (March 31, 2021) https://apm.amegroups.org/article/view/44492/html 27/04/25

with withholding or withdrawal of artificial nutrition and hydration….has gone largely unexamined."[76]

General articles discussing VSED go back before 2000 - in 1993, Bernat et al called for systematic research on VSED[77], but Mensger et al in 2024 found available research dealt less with practice, and "mostly dealing with the ethical and legal issues"[78]. In their literature review Ivanović et al describe existing research as a:

> continuous interweaving of published articles. In this respect, we conclude that the evidence was artificially reproduced over time through repeated citations of narrative reviews without new insights based on original studies.[79]

They note that:

> articles provide marginal insight into VSED for hastening death. Research is needed …. intensive examination of the literature shows that the subject under study has been marginally researched and that there is no scientific basis on which VSED could be explained in all of its dimensions.[80]

3. The problem of a lack of standardised national guidance, and inequality of provision.

Dykes et al observe that "no nationalised information or guidance exists".[81] There appears to be no standardisation nationally of legislation, procedural guidance, structured protocols or support services for patients, patients' families or for medical staff. Ness & Pope also found little research to guide best practice and an expressed need by practitioners for training.[82] Bolt et al note that "There is an increasing call for

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[76] Pope, Thaddeus Mason and Liu, Richard and Xu, April Xiaoyi, Deep and Continuous Palliative Sedation without Artificial Nutrition and Hydration: An International Review (September 14, 2024). 35 Indiana International & Comparative Law Review XXX (forthcoming 2025)., 35(1) Indiana International & Comparative Law Review. 2025: 70. https://ssrn.com/abstract=4956660 or http://dx.doi.org/10.2139/ssrn.4956660

[77] Bernat JL, Gert B, Mogielnicki RP. Patient refusal of hydration and nutrition. An alternative to physician-assisted suicide or voluntary active euthanasia. Arch Intern Med. 1993;153(24):2723–2728.

[78] Christina Mensger, Yang Jiao, Maximiliane Jansky, Christian Banse, Friedemann Nauck, Monika Nothacker, Henrikje Stanze. Voluntarily stopping eating and drinking (VSED): A systematic mixed-methods review focusing on the carers' experiences. Health Policy Volume 150, December 2024, 105174. https://www.sciencedirect.com/science/article/pii/S0168851024001842 27/04/25

[79] Ivanović, Nata & Bueche, Daniel & Fringer, André. (2014). 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. 10.1186/1472-684X-13-1. http://www.biomedcentral.com/1472-684X/13/1 27/04/25

[80] Ivanović, Nata & Bueche, Daniel & Fringer, André. (2014). 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. 10.1186/1472-684X-13-1. http://www.biomedcentral.com/1472-684X/13/1 27/04/25

[81] Dykes et al. Voluntarily stopping eating and drinking—lack of guidance is failing patients and clinicians. BMJ 379:o2621, 2022 https://www.bmj.com/content/379/bmj.o2621

[82] Ness RB, Pope TM. Voluntarily Stopping Eating and Drinking: Systematic Review of Empirical Studies. J Palliat Med. 2025 Aug;28(8):1114-1120.

clinical guidelines for professional caregivers in different countries, similar to the Dutch and American guidelines."[83]

In 2024, the Royal Dutch Medical Association (KNMG) revised their guidelines[84], and produced a brochure for patients and their families[85]. Quill et al propose a set of stages for VSED after any (US) individual has been fully informed of their available options and has chosen VSED:

- Formal Psychiatric Evaluation.
- Formal Advance Care Planning.
- Health Care Proxy - power of attorney.
- Advance Instructional Directive - specific on treatment preferences during VSED.
- Practitioner Orders for Life Sustaining Therapy (POLST) forms - both current care and advance care directives.
- Hospice referral - if required.[86]

Jox et al concluded that "[p]hysicians, lawmakers, and societies should discuss specific ways of regulating medical support for VSED in order to provide clear guidance for both patients and healthcare professionals."[87] There is an absence of standardised guidance specifically in relation to the support of VSED in palliative care in Scotland, the UK, and indeed further afield -as Wechkin et al note in relation to the United States:

> It is an option for those with serious illness that is legal in every state in the country, but for which there are few published comprehensive guidelines—and none specific to the American medical system—even as public awareness and the number of inquiries regarding this action increase.[88]

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[83] Bolt et al. Patients who seek, 2023:543, as above.

[84] Royal Dutch Medical Association (KNMG). Caring for People who Stop Eating and Drinking to Hasten the End of Life. 2024. https://www.knmg.nl/download/guide-caring-for-people-who-stop-eating-and-drinking-to-hasten-the-end-of-life

[85] Royal Dutch Medical Association (KNMG). Stopping Eating and Drinking to Die Sooner (Stoppen met eten en drinken om eerder te overlijden). 2024. https://www.knmg.nl/download/publieksbrochure-stoppen-met-eten-en-drinken-om-eerder-te-overlijden

[86] Quill, Timothy E.; Menzel, Paul T.; Pope, Thaddeus; Schwarz, Judith K.. Voluntarily Stopping Eating and Drinking: A Compassionate, Widely-Available Option for Hastening Death. Kindle Edition. Oxford University Press 2021: 41-45

[87] Jox, Ralf J, Black, Isra, Borasio, Gian Domenico et al. Voluntary stopping of eating and drinking: is medical support ethically justified? BMC Medicine. 186. 2017

[88] Wechkin et al. Clinical Guidelines for Voluntarily Stopping Eating and Drinking (VSED). Journal of Pain and Symptom Management, 2023; 66, e625-e631. https://www.jpsmjournal.com/article/S0885-3924(23)00565-1/fulltext

Batzler et al detail similar issues within the German health system,[89] and Stängle & Fringer note a lack of knowledge amongst health-care professionals in Switzerland and that "[w]hile health professionals are already being confronted with the phenomenon [VSED], there is a lack of discussion at the level of health institutions about how to deal with it."[90] The European Association for Palliative Care (EAPC) updated their framework on palliative sedation in 2024, including:

> proposed assessment tools for monitoring, a comprehensive table of medications, dosages and administration forms, serves as comprehensive and soundly developed information for healthcare professionals on the use of palliative sedation as well as for medical associations and health policy decision-makers.[91]

There is however no specific EAPC guidance on VSED.

It is unclear if there has been an attempt to formalise and implement such a set of guidelines consistently throughout Scotland. VSED is not mentioned in the NHS Scotland guidance 'Caring for people in the last days and hours of life'[92], 'Scottish Palliative Care Guidelines'[93], 'End of life care', 'Care in the last days of life"[94], 'Palliative and end of life care: strategic framework for action'[95], or apparently anywhere else in online documentation. Similarly VSED is not mentioned in NICE's guidance for end-of-life care.

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[89] Batzler et al. Caring for patients during voluntarily stopping of eating and drinking (VSED): experiences of a palliative care team in Germany. BMC Palliative Care 22:185, 2023. https://bmcpalliatcare.biomedcentral.com/articles/10.1186/s12904-023-01308-z

[90] Stängle S, Fringer A. Perspectives of people accompanying a person during voluntary stopping eating and drinking: a convergent mixed methods study. Ann Palliat Med 2021;10(2):1994-2007. doi: 10.21037/apm-20-1339. https://apm.amegroups.org/article/view/60152/pdf

[91] European Association for Palliative Care (EAPC). Revised European Association for Palliative Care (EAPC) recommended framework on palliative sedation: An international Delphi study. Palliative Medicine Vol. 38(2) 2024: 213 –228. https://journals.sagepub.com/doi/pdf/10.1177/02692163231220225

[92] NHS Scotland. Guidance Caring for people in the last days and hours of life. 2014 https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2014/12/caring-people-last-days-hours-life-guidance/documents/00466779-pdf/00466779-pdf/govscot:document/00466779.pdf

[93] NHS Scotland. Scottish Palliative Care Guidelines. https://www.rightdecisions.scot.nhs.uk/scottish-palliative-care-guidelines/

[94] NHS Scotland. Care in the last days of life. https://www.rightdecisions.scot.nhs.uk/scottish-palliative-care-guidelines/last-days-of-life-care-around-dying/care-in-the-last-days-of-life/?searchTerm=fentanyl

[95] NHS Scotland. Palliative and end of life care: strategic framework for action. 2015. https://www.gov.scot/publications/strategic-framework-action-palliative-end-life-care/

There are references to VSED in advisory documents by disparate medical organisations such as the GMC in 2015[96] (but not in the 2024 update[97]), the BMA in 2019[98] and the Royal College of Physicians in 2021[99]. The Association for Palliative Medicine published a brief (three paragraph) position statement in 2024, noting

> Nationally agreed information, advice or guidance for health professionals could help clinical teams navigate clinically and ethically this rare situation. The APM believes that a range of stakeholders would be necessary to be involved in the development of this information, advice or guidance.[100]

Compassion in Dying note that "[t]he lack of guidance on VSED leads to significant inconsistencies in how it is managed by clinicians."[101] Jox et al note that "a clear legal basis for medically supported VSED in statute or common law is often lacking"[102], an observation confirmed by Liu et al who note that "[Deep and Continuous Palliative Sedation Without Artificial Nutrition and Hydration] is often not governed by a clear legal framework".[103] In the absence of standardised national guidelines and protections, compliance to any agreed standards remains problematic.

As things stand, even the level and detail of information available to both the public and to medical staff can often be lacking and inconsistent. A Yougov survey in July 2022 commissioned by Compassion In Dying of over 500 UK professionals found that

> 50% of the respondents did not have correct information about the legal status of VSED" and "94% of the respondents said it would be helpful for health and

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96 General Medical Council, Patients seeking advice or information about assistance to die, June 2015, https://www.gmc-uk.org/-/media/documents/gmc-guidance—when-a-patient-seeks-advice-or-information-about-assistance-to-die_pdf-61449907.pdf

97 Geeral Medical Council. When a patient seeks advice or information about assistance to die. 13 December 2024. https://www.gmc-uk.org/professional-standards/the-professional-standards/when-a-patient-seeks-advice-or-information-about-assistance-to-die

98 British Medical Association, Responding to patient requests for assisted dying: guidance for doctors, June 2019, https://www.bma.org.uk/media/1424/bma-guidance-on-responding-to-patient-requests-for-assisted-dying-for-doctors.pdf

99 Royal College of Physicians, Supporting people who have eating and drinking difficulties, March 2021, https://www.rcplondon.ac.uk/projects/outputs/supporting-people-who-have-eating-and-drinking-difficulties

100 Association for Palliative Medicine (of Great Britain and Ireland (APM)). The APM's Position Statement On VSED August 2024. https://apmonline.org/wp-content/uploads/APM-Position-Statement-on-VSED-.pdf

101 Compassion in Dying. Voluntarily stopping eating and drinking (VSED): A call for guidance. Nov 2022. https://cdn.compassionindying.org.uk/wp-content/uploads/vsed-call-for-guidance-november-2022.pdf

102 Jox, Ralf J, Black, Isra, Borasio, Gian Domenico et al. Voluntary stopping of eating and drinking: is medical support ethically justified? BMC Medicine. 186. 2017

103 Liu, Richard, Pope, Thaddeus Mason and and Xu, April, Deep and Continuous Palliative Sedation without Artificial Nutrition and Hydration: An International Review (September 14, 2024). 35 Indiana International & Comparative Law Review XXX (forthcoming 2025)., 35(1) Indiana International & Comparative Law Review 67-151 (2025), Available at SSRN: https://ssrn.com/abstract=4956660 or http://dx.doi.org/10.2139/ssrn.4956660 https://open.mitchellhamline.edu/cgi/viewcontent.cgi?article=1622&context=facsch 27/04/25

care professionals to have guidance on the legal and clinical aspects of VSED.[104]

Dignity in Dying observe that "[u]nlike other end-of-life practices, there are also no standardised guidelines in the UK for how healthcare professionals should support people who decide to hasten their death via VSED."[105] They note that inadequate pain relief can result from a lack of clear guidance. Uemura et al note that "there is no consensus on whether VSED is natural death or suicide"[106] which in turn creates no received consensus on VSED in general or on such elements as what should be recorded on death certificates.

Support by medical staff is also by no means guaranteed. Compassion in Dying cite recent examples of patients experiencing difficulty in accessing information, being stonewalled, being referred to psychiatric services and in one case a patient requesting VSED being sectioned seven days before his death.[107] They note that "[p]eople have also reported that their healthcare team refused to provide pain relief and symptom management when stopping eating and drinking."[108]

In terms of public awareness, although euthanasia has a page on the NHS Scotland public website, there was still no mention anywhere relating to VSED or VRFF, in acronym or full-form (on April 30 2025).

4. The problem of no standardised protections against malfeasance

Quill et al note that "[a]mong other 'last resort' decisions, VSED raises the fewest concerns that the choice is voluntary[109]. An argument can be made however that VSED merits the same safeguards for any individual as are regarded as necessary for AD.

There is no evidence that availability of VSED as a choice has been abused by individuals targeting the vulnerable or that coercion has played a part in VSED in Scotland. However, it is also fair to say that without similar safeguards proposed by Liam McArthur in his Bill for AD, and the concomitant centralised record-keeping and analysis, there remains little collated data upon which to mount an analysis. As

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[104] Compassion in Dying. Voluntarily stopping eating and drinking (VSED): A call for guidance. Nov 2022: 12. https://cdn.compassionindying.org.uk/wp-content/uploads/vsed-call-for-guidance-november-2022.pdf

[105] Dignity In Dying: The Inescapable Truth About Dying in Scotland (2019): study commissioned by the campaign group Dignity in Dying and conducted by the Office of Health Economics, a research company. https://features.dignityindying.org.uk/inescapable-truth/

[106] Uemura T, Krohmal B, Higuchi M. Challenges in Completing a Death Certificate after Voluntary Stopping of Eating and Drinking (VSED). Journal of the American Medical Directors Association, 2023; 24, 1442-1446. https://www.jamda.com/action/showCitFormats?doi=10.1016/j.jamda.2023.06.022&pii=S1525-8610(23)00612-6

[107] Compassion in Dying. Voluntarily stopping eating and drinking (VSED): A call for guidance. Nov 2022 8. https://cdn.compassionindying.org.uk/wp-content/uploads/vsed-call-for-guidance-november-2022.pdf

[108] Compassion in Dying. Voluntarily stopping eating and drinking (VSED): A call for guidance. Nov 2022: 9. https://cdn.compassionindying.org.uk/wp-content/uploads/vsed-call-for-guidance-november-2022.pdf

[109] Quill TE, Ganzini L, Truog RD, et al. Voluntarily Stopping Eating and Drinking Among Patients With Serious Advanced Illness-Clinical, Ethical, and Legal Aspects. JAMA Intern Med 2018;178:123-7. 125

things stand, it remains an assumption that most if not all individuals initiating VSED will be asked if it is their autonomous choice to sign an advance directive form and proceed. However, questions can be asked as to whether an appropriate degree of scrutiny is applied, or whether coercion is a significant risk. The lack of public scrutiny or indeed data collection and analysis leaves an uncomfortable lack of clarity. It would appear to make sense to offer checks within the ambit of a similar monitoring and protection system to that proposed in the McArthur Bill. Without an agreed national multi-stage process of checks, safeguards and data collection such questions will persist.

5. The problem with suffering: it may well be a longer and more unpleasant process than has been understood

A great deal of assumptions on the lack of discomfort of VSED could be argued to be received wisdom, within a context of the dearth of actual research. Pope & Anderson argue that "[t]here is a good amount of anecdotal evidence that a death incident to VSED is peaceful, painless, and dignified."[110] There is however evidence suggesting that discomfort and delirium are experienced in VSED for at least some of those who choose to remain conscious. It can be noted that after failed legal cases to access AD in the UK, both Debbie Purdy and Tony Nicklinson ended their lives via VSED.[111] Purdy described the time taken to die as "agonising".[112] The lack of lack of relevant research and standardised national guidance on delivery, along with potential inequality of provision noted earlier must also raise concerns as to the consistency and efficacy of support and treatment available.

Pope and West[113] note that while some undergoing VSED may experience euphoria and tranquility, others have been observed to experience pain, delirium and anxiety. The Royal Dutch Medical Association advise on treatments specifically complications from dehydration, problems with micturition and defecation, pain, nausea and vomiting, restlessness, confusion and delirium.[114] Van Dijk et al state that

> The process of dying occurs in three phases, which gradually merge into one another. The first phase (three to four days) is defined when eating and drinking are acutely or gradually stopped, and the feeling of hunger usually disappears, provided that no carbohydrates are ingested. During the middle phase (variable length) pain or signs of delirium can occur. Painkillers and sleeping pills are the most commonly prescribed

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[110] Pope & Anderson. 2011:389, as above.

[111] Richards, N. Is the voluntary refusal of food and fluid an alternative to assisted dying? University of Glasagow, End of Life Studies. July 16, 2015. https://endoflifestudies.academicblogs.co.uk/voluntary-refusal-of-food-and-fluid-as-alternative-to-assisted-dying/

[112] Wikipedia. Debby Purdy. https://en.wikipedia.org/wiki/Debbie_Purdy#:~:text=Purdy entered the Marie Curie,23 December 2014, aged 51.

[113] Thaddeus Mason Pope and Amanda West, "Legal Briefing: Voluntarily Stopping Eating and Drinking," The Journal of Clinical Ethics 25, no. 1 (Spring 2014): 68-80.

[114] Royal Dutch Medical Association (KNMG). Guide: Caring for people 2024: 50-56, as above.

> palliative medication. Although thirst is generally not a prominent complaint, proper oral care is essential to prevent and alleviate complaints of thirst or dry mouth. The final phase (several days) is comparable to the dying phase of a terminal illness.[115]

While some discomfort is recognised above, the view that VSED is primarily free of suffering is not held by all researchers. Professor Stephen Duckworth describes VSED as "a long, slow, cruel death.[116]

Starvation and dehydration can be a slow and unpleasant process. Bolt et al found that "in 8% of cases, dying was a prolonged process of more than 14 days"[117], Ness & Pope found that "[t]he mean time to death was 10 days with a range of one to two weeks",[118] while Quill et al found that "[t]he process of VSED until death may take up to 21 days"[119]. Wax et al state that "VSED is an intense process fraught with new sources of somatic and emotional suffering for individuals and their caregivers"[120]. Jean Davis, while undergoing VSED while conscious, described the experience as: "It is hell. I can't tell you how hard it is. You wouldn't decide this unless you thought your life was going to be so bad. It is intolerable."[121] The Patients Rights Council describes the process as follows:

> As a person dies from dehydration, his or her mouth dries out and becomes caked or coated with thick material; lips become parched and cracked; the tongue swells and could crack; eyes recede back into their orbits; cheeks become hollow; lining of the nose might crack and cause the nose to bleed; skin begins to hang loose on the body and becomes dry and scaly; urine would become highly concentrated, leading to burning of the bladder; lining of the stomach dries out, likely causing the person to experience dry heaves and vomiting; body temperature can become very high; brain cells dry out, causing convulsions; respiratory tract also dries out causing thick secretions that could

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[115] van Dijk G, Derckx V, de Graeff, A. Voluntarily Stopping Eating and Drinking as Self-chosen Path for End of Life. World Medical Journal. Nr. 2, June 2025. https://www.wma.net/wp-content/uploads/2025/06/WMJ_02_2025.pdf#page=19

[116] Duckworth, Prof Stephen (2022) *Written evidence submitted by Professor Stephen Duckworth OBE, DSc, PhD, FKC, MSc LRCP MRCS (ADY0002)* UK Parliament. https://committees.parliament.uk/writtenevidence/114065/pdf/

[117] Bolt EE, Hagens M, Willems D, Onwuteaka-Philipsen BD. Primary care patients hastening death by voluntarily stopping eating and drinking. Ann Fam Med. 2015 Sep;13(5):421-8. doi: 10.1370/afm.1814. PMID: 26371262; PMCID: PMC4569449.

[118] Ness & Pope. Voluntarily Stopping Eating and Drinking: Systematic Review of Empirical Studies. 2025, as above.

[119] Quill TE, Lo B, Brock DW. Palliative options of Last Resort: a comparison of voluntarily stopping eating and drinking, terminal sedation, physician-assisted Suicide, and Voluntary active euthanasia. Springer Science + Business Media B.V.; 2008.

[120] Wax JW, An AW, Kosier N, Quill TE. Voluntary Stopping Eating and Drinking. J Am Geriatr Soc. 2018 Mar;66(3):441-445. doi: 10.1111/jgs.15200. PMID: 29532465.

[121] Guardian. Sun 19 Oct 2014 14.19 BST https://www.theguardian.com/society/2014/oct/19/right-to-die-campaigner-starved-herself-jean-davies 28/04/25

> plug the lungs and cause death. At some point the person's major organs, including the lungs, heart, and brain give out and death occurs.[122]

Proper palliative care can reduce the suffering of the patient as they starve and dehydrate. Wechkin et al note that for those who remain awake experiencing VSED, "end-of-life dreams and visions….may be eased with antipsychotic medications"[123]. However the Patients Rights Council cite a case where despite a patient being "administered small doses of morphine to combat cramps and a sedative to relieve 'emotional anxiety" after more than a fortnight she was "howling with anguish."[124]

It is also reasonable to note the same option to offer medication in response to visible suffering is not available to those in induced unconsciousness whose peaceful stillness may belie a far from peaceful experience. Those who look on may feel reassured by the apparent peace of their loved one in an apparent comatose state. The patient however may be experiencing traumatic delirium and physical discomfort.

Where unconsciousness has been induced, any mental or physical suffering is generally not apparent. As noted by Sheen & Oates: "The absence of physical responses should not be misinterpreted to mean that cognitive processes are not occurring."[125] In such cases of induced unconsciousness the sufferer is unconscious for the entire period, paralysed and non-responsive, and can no longer communicate or interact or wake up and change their mind. This persists until death.

Nilsen et al note that "states presumed to be unconscious are not always devoid of reported experience", and that

> [c]areful studies have provided evidence that dreaming occurs surprisingly often in deep non-REM slow-wave sleep stages (Suzuki et al., 2004; McNamara et al., 2010; Windt et al., 2016; Siclari et al., 2017, 2018), as well as during general anesthesia (Käsmacher et al.,1996; Brandner et al., 1997; Leslie et al., 2007, 2009; Eeret al., 2009; Noreika et al., 2011; Leslie, 2017).[126]

In addition to the possibility of delirium whilst unconscious, there is a possibility that pain is experienced. O'Connor et al note that in dying patients as "conscious level deteriorates so too does their ability to reason, to process information and

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[122] The Patients Rights Council. Voluntarily Stopping Eating & Drinking: Important Questions & Answers https://www.patientsrightscouncil.org/site/wp-content/uploads/2013/03/VSED_Questions.pdf 28/04/25

[123] Hope Wechkin, Robert Macauley, Paul T. Menzel, Peter L. Reagan, Nancy Simmers, Timothy E. Quill. Clinical Guidelines for Voluntarily Stopping Eating and Drinking (VSED). Journal of Pain and Symptom Management. Volume 66, Issue 5E625-E631November 2023 https://www.jpsmjournal.com/article/S0885-3924(23)00565-1/fulltext 27/04/25

[124] The Patients Rights Council. As above.

[125] Sheen, L & Oates, J. A phenomenological study of medically induced unconsciousness in intensive care. Australian Critical Care Volume 18, Issue 1, February 2005, Pages 25-32. https://www.sciencedirect.com/science/article/abs/pii/S1036731405800219#preview-section-abstract

[126] Sevenius Nilsen A, Juel BE, Thürer B, Aamodt A and Storm JF (2022) Are we really unconscious in "unconscious" states? Common assumptions revisited. Front. Hum. Neurosci. 16:987051. doi: 10.3389/fnhum.2022.987051

instructions, and articulate their needs or a response to stimuli"[127], recommending that based on available evidence of continued cognition that patients should be regarded as unresponsive rather than unconscious. This has clear implication for both existing assumptions of VSED as a 'peaceful experience' and to palliative care requirements. Due to the lack of specific research on VSED patients in induced unconsciousness, it may be useful to look at research in relation to nociception in patients in Minimally Conscious State (MCS) and Vegetative State (VS)/Persistent Vegetative State (PVS).

Patients in a MCS appear to register and experience pain. A key question, based on the drug regimen applied to render the patient unresponsive during VSED and until death, is whether the patient is rendered closer to an unresponsive minimally conscious state or an unconscious vegetative state. If the former, there is a definite possibility that the patient could experience both pain and delirium, or indeed move between both states, while being unable to indicate experienced discomfort in either. Demertzi et al note from their European survey of 2059 medical and paramedical professionals that

> "To the question ''Do you think that patients in a minimally conscious state can feel pain?'' nearly all interviewed caregivers answered ''yes'' (96% of the medical doctors and 97% of the paramedical caregivers)."[128]

Boly et al found:

> In patients in MCS and in controls, noxious stimulation activated the thalamus, S1, and the secondary somatosensory or insular, frontoparietal, and anterior cingulate cortices (known as the pain matrix). No area was less activated in the patients in MCS than in the controls. All areas of the cortical pain matrix showed greater activation in patients in MCS than in those in PVS. Finally, in contrast with patients in PVS, those in MCS had preserved functional connectivity between S1 and a widespread cortical network that includes the frontoparietal associative cortices.[129]

Schnakers et al note that:

> while vegetative patients only show reflexive activity, patients in a minimally conscious state demonstrate inconsistent, elementary but reproducible signs of consciousness, and can sometimes verbalize, but they do not show functional

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[127] O'CONNOR, T., PATERSON, C., GIBSON, J. and STRICKLAND, K. 2022. The conscious state of the dying patient: an integrative review. Palliative supportive care [online], 20(5), pages 731-743. 4 https://doi.org/10.1017/S1478951521001541

[128] A. Demertzi, C. Schnakers, D. Ledoux, C. Chatelle, M.-A. Bruno, A. Vanhaudenhuyse, M. Boly, G. Moonen and S. Laureys. Different beliefs about pain perception in the vegetative and minimally conscious states: a European survey of medical and paramedical professionals. CHAPTER 22, S.Laureys et al. (Eds.) Progress in Brain Research, Vol. 177 ISSN 0079-6123 https://www.academia.edu/8996148/Different_beliefs_about_pain_perception_in_the_vegetative_and_minimally_conscious_states_a_European_survey_of_medical_and_paramedical_professionals

[129] Boly M, Faymonville ME, Schnakers C, Peigneux P, Lambermont B, Phillips C, Lancellotti P, Luxen A, Lamy M, Moonen G, Maquet P, Laureys S. Perception of pain in the minimally conscious state with PET activation: an observational study. Lancet Neurol. 2008 Nov;7(11):1013-20. doi: 10.1016/S1474-4422(08)70219-9. Epub 2008 Oct 3. PMID: 18835749.

> communication that could be used for pain assessment. Recent studies suggest that minimally conscious patients can experience pain to some extent.[130]

Neuroimaging for vegetative state patients and minimally conscious state patients by Demertzi et al indicated that

> [i]n striking contrast to what we observed in VS, MCS patients showed activation in not only midbrain, thalamus, and primary somatosensory cortex but also in secondary somatosensory, insular, posterior parietal, and anterior cingulate cortices. The spatial extent of the activation in MCS patients was comparable to controls and no brain region showed less activation in MCS as compared to healthy individuals. A functional connectivity assessment of insular cortex demonstrated its preserved connections with a large set of associative areas encompassing posterior parietal, motor and supplementary motor, striatum, and dorsolateral prefrontal and temporal associative cortices as observed in controls (Boly et al., 2005). These neuroimaging data show large differences in brain activation between VS and MCS patients, despite a similar bedside behavioral evaluation.[131]

Schnakers & Zasler[132], Boly et al[133], and Wade & Hanrahan[134] suggest that patients in a vegetative state may remain inured to any pain stimulation. Schnakers et al posit that

> future research will need to address the relationship between pain perception and the experience of suffering in patients in a MCS. Pain perception must be differentiated from suffering, as the latter involves a complex cognitive–affective phenomenon, involving not only a negative emotional response to the pain experience, but also the ability to remember that particular experience or set of experiences.[135]

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[130] Schnakers, Caroline; Chatelle, Camille; Majerus, Steve; Gosseries, Olivia; De Val, Marie & Laureys, Steven. Assessment and detection of pain in noncommunicative severely brain-injured patients Expert Rev. Neurother. 10(11), 1725–1731 (2010).

[131] Demertzi et al. Different beliefs about pain. 2009: , as above.

[132] Caroline Schnakers & Nathan Zasler. Assessment and Management of Pain in Patients With Disorders of Consciousness. PM&R Volume 7, Issue 11, Supplement, November 2015, Pages S270-S277 https://www.sciencedirect.com/science/article/abs/pii/S1934148215010242#preview-section-references

[133] Mélanie Boly, Marie-Elisabeth Faymonville, Caroline Schnakers, Philippe Peigneux, Bernard Lambermont, Christophe Phillips, Patrizio Lancellotti, Andre Luxen, Maurice Lamy, Gustave Moonen, Pierre Maquet, Steven Laureys. Perception of pain in the minimally conscious state with PET activation: an observational study. The Lancet Neurology, Volume 7, Issue 11, 2008, Pages 1013-1020, ISSN 1474-4422, https://www.sciencedirect.com/science/article/abs/pii/S1474442208702199

[134] Wade, Derick T & Hanrahan, Andrew. Do some people with a prolonged disorder of consciousness experience pain? A clinically focused narrative review and synthesis. Clinical Rehabilitation 2025, Vol. 39(6) 796–807. DOI: 10.1177/02692155251333540. https://journals.sagepub.com/doi/pdf/10.1177/02692155251333540

[135] Schnakers, Caroline; Chatelle, Camille; Majerus, Steve; Gosseries, Olivia; De Val, Marie & Laureys, Steven. Assessment and detection of pain in noncommunicative severely brain-injured patients Expert Rev. Neurother. 10(11), 1725–1731 (2010).

The above indicates a clear difference in level of brain activity between MCS and VS, and by inference equivalent states that may be experienced by patients undergoing terminal sedation as part of VSED. However, the possibility of some degree of nociception during the equivalent of VS may not be discounted. Owen et al note that "37% to 43% of patients who receive the diagnosis of a persistent vegetative state can be demonstrated by careful, standardized clinical examination on the basis of the Coma Recovery Scale (CRS-R) to have at least minimally preserved consciousness.[136] Wade and Hanrahan also observe that patients with "a prolonged disorder of consciousness….may have episodes of transitive occurrent ('in the moment') consciousness of mental states when awake. This state is likely to be an unpleasant one with a negative experience of pain."[137]

Correctly assessing care needs for patients experiencing an 'altered conscious state' has always been challenging. Providing appropriate relief even for VSED patients who have chosen to remain conscious during the process may therefore be problematic as the patient approached death and may become less coherent or rendered unresponsive by drugs. The challenge will be even greater for those who have chosen induced unconsciousness from the beginning of VSED.

Herr et al observe that "[i]ndividuals who are unable to communicate their pain are at greater risk for under recognition and under-treatment of pain."[138] Schnakers et al note that:

> [e]ven if they present some level of consciousness, MCS patients are unable to consistently or reliably communicate their feelings and possible conscious pain perception. Hence, it is of utmost importance to develop sensitive tools to assess the level of pain perception in these patients.[139]

Nazari et al note:

> most patients in ICU cannot report their pain due to altered consciousness, mechanical ventilation, or sedation. Despite great efforts to accurately assess pain in patients in the ICU, their pain is still underestimated or remains undiagnosed and unmanaged.[140]

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[136] Owen AM, Coleman MR, Boly M, Davis MH, Laureys S, Pickard JD. Detecting awareness in the vegetative state. Science. 2006 Sep 8;313(5792):1402. doi: 10.1126/science.1130197. PMID: 16959998.

[137] Wade, Derick T & Hanrahan, Andrew. Do some people with a prolonged disorder of consciousness experience pain? A clinically focused narrative review and synthesis. Clinical Rehabilitation 2025, Vol. 39(6) 796–807. DOI: 10.1177/02692155251333540. https://journals.sagepub.com/doi/pdf/10.1177/02692155251333540

[138] Keela Herr, Patrick J. Coyne, Margo McCaffery, Renee Manworren, & Sandra Merkel. Pain Assessment in the Patient Unable to Self-Report: Position Statement with Clinical Practice Recommendations. Pain Management Nursing Volume 12, Issue 4, December 2011, Pages 230-250 https://www.sciencedirect.com/science/article/abs/pii/S1524904211001883

[139] Schnakers et al. Assessment and detection of pain 2010:

[140] Nazari R, Froelicher ES, Nia HS, Hajihosseini F, Mousazadeh N. Diagnostic Values of the Critical Care Pain Observation Tool and the Behavioral Pain Scale for Pain Assessment among Unconscious Patients: A Comparative Study. Indian J Crit Care Med. 2022 Summer;26(4):472-476. doi: 10.5005/jp-journals-10071-24154. PMID: 35656052; PMCID: PMC9067504.

Fratino et al note that "[d]etection of inadequate pain control might vary according to the method used to assess nociception in ICU patients"[141] and O'Connor at al note a "lack of suitable assessment tools to determine and assess care needs when the dying patient's conscious state changes".[142] Formisano et al note the need for more in-depth research and better application of personalised and "more aggressive and appropriate pain management"[143] for patients with a disorder of consciousness. They recommend a revised Nociception Coma Scale (NCS-R), but acknowledge that "Functional communication impairments in patients with Vegetative State (VS)/Unresponsive Wakefulness Syndrome (UWS) and Minimally Conscious State (MCS) makes assessment of pain a challenging task"[144], dealing with different forms of pain and a variety of sensory perception abnormalities.

Lack of research specifically on this process in relation to unconscious VSED patients leaves cause for concern as to how unpleasant the experience can be. No nociception measurement tools appear to have been applied during VSED, but as noted earlier, those who choose to remain conscious during VSED can become agitated, confused, distressed and in a great deal of discomfort up until the end.

There is therefore some evidence to suggest that despite heavy dosage sedation there still may be some experience of nociception and delirium. In a minimally conscious state it is clear that both can be experienced. The difficulty, without applying more sophisticated measurement during unconscious VSED, is that one state (MCS) may not be differentiated from another (VS). The unconscious individual is unable to express suffering and seek relief. The overall experience of each patient may indeed vary from MCS to something more akin to VS depending on dosage and as the body weakens and organs fail. Unresponsive remains unresponsive and a poor guide to actual experience. Without a better understanding of patient experience during induced unconsciousness VSED and clear standardised guidelines as to the optimum use of sedation to induce and maintain the most appropriate level of

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[141] Fratino, S.; Peluso, L.; Talamonti, M.; Menozzi, M.; Costa Hirai, L.A.; Lobo, F.A.; Prezioso, C.; Creteur, J.; Payen, J.-F.; Taccone, F.S. Evaluation of Nociception Using Quantitative Pupillometry and Skin Conductance in Critically Ill Unconscious Patients: A Pilot Study. *Brain Sci*. **2021**, *11*, 109. https://doi.org/10.3390/brainsci11010109

[142] O'CONNOR, T., PATERSON, C., GIBSON, J. and STRICKLAND, K. 2022. The conscious state of the dying patient: an integrative review. Palliative supportive care [online], 20(5), pages 731-743. 4 https://doi.org/10.1017/S1478951521001541

[143] Formisano R, Aloisi M, Ferri G, Schiattone S, Estraneo A, Magliacano A, Noé E, Pérez MDN, Hakiki B, Romoli AM, Bertoletti E, Leonardi G, Thibaut A, Martial C, Gosseries O, Brisbois M, Lejeune N, O'Valle M, Ferri J, Frédérick A, Zasler N, Schnakers C, Iosa M. Nociception Coma Scale-Revised with Personalized Painful Stimulus Versus Standard Stimulation in Persons with Disorders of Consciousness: An International Multicenter Study. J Clin Med. 2024 Sep 18;13(18):5528. doi: 10.3390/jcm13185528. PMID: 39337015; PMCID: PMC11432094. https://pmc.ncbi.nlm.nih.gov/articles/PMC11432094/

[144] Formisano R, Aloisi M, Ferri G, Schiattone S, Estraneo A, Magliacano A, Noé E, Pérez MDN, Hakiki B, Romoli AM, Bertoletti E, Leonardi G, Thibaut A, Martial C, Gosseries O, Brisbois M, Lejeune N, O'Valle M, Ferri J, Frédérick A, Zasler N, Schnakers C, Iosa M. Nociception Coma Scale-Revised with Personalized Painful Stimulus Versus Standard Stimulation in Persons with Disorders of Consciousness: An International Multicenter Study. J Clin Med. 2024 Sep 18;13(18):5528. doi: 10.3390/jcm13185528. PMID: 39337015; PMCID: PMC11432094. https://pmc.ncbi.nlm.nih.gov/articles/PMC11432094/

unconsciousness, underlying experience of delirium and physical suffering cannot be discounted.

Of course, even if suffering may be experienced, whether conscious or unconscious, it must be considered within the context of the comparably greater suffering anticipated (or indeed already being experienced) that the individual is seeking to circumvent. It may well be a choice for some of a lesser harm over a greater one. For some it may be a preferred choice solely because the AD is not legally available. Nonetheless, it would seem desirable to be able to apply greater nociception detection during the VSED process. In the absence of such monitoring and adjustments, should patients be warned of the potential discomfort during drug-induced paralysis?

Finally, in addition to doubts that may remain about the peaceful and humane nature of the process for the dying patient, the process can also be a prolonged and traumatic deathwatch for their loved ones, where days can extend into weeks. There is also a sense of abandoning their loved one experienced by those who cannot stay 24 hours a day over such an extended death, due to the many other life commitments they may have. They may well be robbed of the catharsis from being with their loved one at the end, an outcome allowed by AD. As the outcome of VSED is both foreseeable and intended, a common question is why deaths need to be dragged out for the sufferer and their loved ones when supply and/or administration of a more immediately lethal dosage could allow a more compassionate and shared goodbye, as is available in other countries.

Summary

VSED is most definitely a form of suicide, and although some argue that it is also a form of assisted suicide, considering that there is often a clear level of support by medical staff, it can perhaps better be said to be medically facilitated or enabled suicide, as fine as that distinction may be.

There remains insufficient formal standardised guidance for delivery, information-sharing or for safeguards for the public, and insufficient research on such factors as level of nociception. There is a growing recognition of the need for further research, and further testing of pre-existing assumptions.

Despite the hopes and claims of supporters, a case can be made (despite further research being required) that VSED can be a considerably more unpleasant experience than is generally claimed. However even a more problematic VSED may ultimately cause less harm and suffering to those than the alternative that many face. In the absence of legally available Assisted Dying in Scotland, it remains an available, if imperfect, legal option for many of those seeking to accelerate their death.

Citations and web addresses checked and confirmed Xth May 2026.

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