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POINT/COUNTERPOINT

Voluntary Stopping of Eating and Drinking (VSED), Physician-Assisted Death (PAD), or Neither in the Last Stage of Life? Both Should be Available as a Last Resort

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A.A. was a 60-year old man with refractory metastatic cancer who requested a palliative care consultation to explore potential future access to physician-assisted death (PAD). (I recommend using the term "physician-assisted death" because from a meaning point of view this practice has nothing to do with "suicide." In fact, for patients like A.A., this option has more to do with self preservation than self destruction.) I initially responded that I could not provide this option because of legal restrictions in New York, but that I would help him find a solution when and if the time came. We explored other legally available "last resort" possibilities[1,2] including potentially voluntarily stopping eating and drinking (VSED). He initially thought that this latter option was nothing a humane society would put its dying patients through, and we agreed to do our best to address whatever the future held for him.

With expert palliative treatment he remained acceptably comfortable and functional over the next year despite widespread skeletal metastases until the day he spontaneously fractured his femoral head. He once again asked for medication to end his life, but instead we braced his leg, increased his analgesia, and sent him home with added hospice support. He returned within 24 hours with a spontaneous hip fracture. Over the next several days, he fractured more bones and experienced serious pain whenever he moved, and he feared more fractures just from turning over in bed. He was prepared for death, and adamantly wanted PAD—the "sooner the better." He was receiving state-of-the-science palliative care, and despite this he was severely suffering both physically and psychologically. We discussed VSED alongside aggressive symptom management as his only option for a hastened death. He again spoke about how absurd and immature this seemed to him in comparison to PAD, but he ultimately accepted this was his "least worst" option.[3] We maintained pain relief with a concentrated opioid infusion and kept his mouth as moist as possible.

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Family and friends said goodbye, and he gradually became sedated and died 10 days later.

A.A. would be typical of patients seeking PAD in states where the practice is legal.[4,5] He had a clearly defined terminal illness and wanted control over his dying. If he resided in Oregon, I would have initially reassured him that I would potentially make PAD available in the future if his suffering became unacceptable, and he would not have been as worried. When his suffering later became unacceptable, I would have carefully evaluated him for undertreated pain or unrecognized depression, and I could have legally offered him either PAD or VSED. He personally found VSED to be absurd, and he had no moral qualms about PAD. Because of laws in New York State prohibiting PAD, he was forced to make end-of-life choices that were inconsistent with his own values.

This is not to say that VSED is always a bad option. In my opinion, VSED should be subject to similar guidelines to those that cover PAD, including: (1) clear understanding of the disease and prognosis; (2) careful evaluation of the patient's unacceptable suffering; (3) full access to modern palliative measures; (4) ensuring the patient's full decision-making capacity; and (5) an independent second opinion by a palliative care expert. Even in environments where PAD is legally available, some patients will still preferentially choose VSED.[6] The psychological impact of voluntarily choosing VSED among a range of other last resort possibilities is very different from having this choice imposed upon a patient who would have preferred PAD. Although A.A. appreciated having an escape from suffering under his control, he found VSED to be more cruel and absurd than meaningful. The opposite may be true for others who would never choose PAD even if legally available because of their own moral beliefs, but they might be able to accept VSED if it did not violate their fundamental personal values.

VSED and PAD are similar in many ways: (1) both result in a wished for death; (2) both require considerable patient resolve; (3) the patient's intent is essentially the same; and (4) both technically would be classified as suicide, but neither have anything inherently to do with mental illness. There are also important differences: (1) VSED takes longer and is harder to accomplish, as patients get very thirsty as it unfolds; (2) the doctor's role in VSED is more indirect (38% of patients in the study by Bolt et al had no physician involvement),[6] where physician involvement is more direct in PAD (doctor provides the means but the patient must independently take the medication); (3) the esthetics of the processes are different; VSED usually takes 1 to 2 weeks with a series of medical and social challenges, whereas PAD is a definitive medical intervention with death expected in minutes to hours; and (4) if PAS is chosen in states where it is illegal, both the clinician and the family must keep a major secret to prevent legal complications, potentially complicating grief, whereas VSED can be openly and legally practiced anywhere in the United States.

When a suffering patient requests VSED or PAD, the first steps should always be a careful evaluation to understand why, to ensure the adequacy of palliative care, and to assess the patient's decision-making capacity. While a patient's values and preference remain in the center of decision making, evaluating clinicians must also take into account legal limits and their personal values. VSED can be an important option for some suffering patients who wish an earlier death, but the meaning attached to this practice can vary considerably from a welcomed, patient-controlled escape to an absurd end that adds to suffering as much or more than alleviating it. Furthermore, VSED also takes too long to adequately respond to overwhelming, immediate physical suffering. The comparative risks, benefits and burdens of these last resort practices continue to be debated among well-intended, sophisticated, experienced palliative care practitioners as well as the broader society as we try to find better ways to respond to those infrequent but very troubling patients who suffer unacceptably despite receiving state of the science palliative care.

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