

Assisted Deaths Prior to the Voluntary Assisted Dying Act 2017 (Vic): Would Patients Have Met the Eligibility Criteria to Request Voluntary Assisted Dying?

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Unlawful assisted dying practices have been reported in Australia for decades. Voluntary assisted dying (VAD) is now lawful in Victoria and Western Australia in limited circumstances and will soon be lawful in a further four Australian States. This article examines nine cases involving unlawful assisted dying practices in Victoria in the 12 months prior to the commencement of the Voluntary Assisted Dying Act 2017 (Vic) in 2019. It explores whether, if that Act had been in operation at the relevant time, these patients would have been eligible to request VAD, having regard to their decision-making capacity and their disease, illness or medical condition. Many of these patients would not have been eligible to request VAD had the legislation been operational, primarily because they lacked decision-making capacity. As VAD is lawful only in a narrow set of circumstances, unlawful assisted deaths may continue to occur in those States where voluntary assisted dying is legal.

Keywords: assisted dying; end-of-life decision-making; health law; medical law

I. INTRODUCTION

In 2017, Victoria became the first Australian State¹ to legalise voluntary assisted dying (VAD) when it passed the *Voluntary Assisted Dying Act 2017* (Vic) (*VAD Act*), which entered in force on 19 June 2019. Following this, there has been a wave of VAD law reform across the country. VAD laws have been enacted in Western Australia in 2019,² in Tasmania, South Australia and Queensland in 2021,³ and in

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¹ VAD was also briefly legal in the Northern Territory from 1996 to 1997 under the *Rights of the Terminally Ill Act 1995* (NT). That law was overturned by the Commonwealth government using its power to legislate directly for the territories: *Euthanasia Laws Act 1997* (Cth).

² The *Voluntary Assisted Dying Act 2019* (WA) was passed in December 2019 and commenced on 1 July 2021.

³ The *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) was passed in March 2021 and will commence on or before 22 October 2022. The *Voluntary Assisted Dying Act 2021* (SA) passed in June 2021 and is expected to commence early to mid-2023. The *Voluntary Assisted Dying Act 2021* (Qld) passed in September 2021 and is expected to commence on 1 January 2023.

New South Wales in 2022.⁴ In the Territories, VAD will remain illegal while the Commonwealth law prohibiting the Territories from legislating on the issue remains in force.⁵

Alongside and prior to this legislative reform in Australia, there is evidence that unlawful activity related to providing assistance to end a person's life has been occurring.⁶ Importantly, there is also evidence that some of this unlawful activity has been performed by doctors.⁷ Further, Australian research has found that many doctors who have undertaken such activity have done so more than once.⁸

There is mixed evidence regarding the influence of doctors' socio-demographic variables such as age, gender and religious affiliation on assisted dying practice;⁹ it is also unclear whether concerns about illegality contribute to refusal of requests for assistance to die that are made by their patients.¹⁰ Assisted dying is more likely to be practised where the patient is not depressed and has a short life expectancy;¹¹ in fact it is likely that most doctors believe that hastening of death in the final hours, when death is already inevitable and imminent, should not be considered assisted dying.¹²

There are also data that provide evidence about when and why patients request their medical practitioner to assist them to die. Studies show that patient requests for VAD are often made late in the trajectory¹³ of a terminal illness (often cancer). Common reasons for assisted dying requests include persistent and

⁴ The *Voluntary Assisted Dying Act 2022* (NSW) was passed on 19 May 2022 and is expected to commence late 2023.

⁵ The Northern Territory and Australian Capital Territory received their powers of self-government from the Commonwealth by way of legislative enactment. Amendments to those self-government acts were introduced by the *Euthanasia Laws Act 1997* (Cth), prohibiting the territories legislating to permit euthanasia, mercy killing, or assisting another person to end their life: *Northern Territory (Self-Government) Act 1978* (Cth) s 50A; and *Australian Capital Territory (Self-Government) Act 1988* (Cth) s 23(1A).

⁶ R Magnusson and PH Ballis, *Angels of Death: Exploring the Euthanasia Underground* (Yale University Press, 2002); P Baume and E O'Malley, "Euthanasia: Attitudes and Practices of Medical Practitioners" (1994) 161(2) *Med J Aust* 137; CD Douglas et al, "The Intention to Hasten Death: A Survey of Attitudes and Practices of Surgeons in Australia" (2001) 175(10) *Med J Aust* 511; C Douglas, I Kerridge and R Ankeny "Managing Intentions: The End-of-life Administration of Analgesics and Sedatives, and the Possibility of Slow Euthanasia" (2008) 22(7) *Bioethics* 388; H Kuhse and P Singer, "Doctors' Practices and Attitudes Regarding Voluntary Euthanasia" (1988) 148 *Med J Aust* 623; DA Neil et al, "End-of-Life Decisions in Medical Practice: A Survey of Doctors in Victoria (Australia)" (2007) 33 *J Med Ethics* 721; R Hassan, "Euthanasia and the Medical Profession: An Australian Study" (1996) 31(3) *Aust J Soc Issues* 239; H Kuhse et al, "End-of-life Decisions in Australian Medical Practice" (1997) 166(4) *Med J Aust* 191; Legal and Social Issues Committee, Parliament of Victoria, Legislative Council, *Inquiry into End of Life Choices: Final Report 2016* Parli Paper No 174 (9 June 2016); K Del Villar, L Willmott and B White, "Suicides, Assisted Suicides and 'Mercy Killings': Would Voluntary Assisted Dying Prevent These 'Bad Deaths'?" (2021) 46(2) *Mon ULR* 141.

⁷ Baume and O'Malley, n 6, 140; Kuhse and Singer, n 6, 624; Hassan, n 6, 246.

⁸ In 1988, Kuhse and Singer reported that 80% of doctors in Victoria who had actively taken steps to end a patient's life had done so more than once, with 19% doing so more frequently than three times: Kuhse and Singer, n 6, 624. In 1994, Baume and O'Malley reported that 61% of doctors in New South Wales or the Australian Capital Territory who had assisted a person to die had done so more than once: Baume and O'Malley, n 6, 140. This finding is consistent with the findings of a systematic review of the international literature which reported that doctors are more likely to practise assisted dying when they are familiar with the act (through past behaviour): L Vézina-Im et al, "Motivations of Physicians and Nurses to Practice Voluntary Euthanasia: A Systematic Review" (2014) 13(1) *BMC Palliat Care* 20, 32.

⁹ See, eg, Kuhse and Singer, n 6, 624; Hassan, n 6, 248; Neil et al, n 6, 723.

¹⁰ Kuhse and Singer, n 6, 624 found that the illegality of the act was a factor in refusing a request for assistance to die for 65% of doctors who refused, compared to 51% in Baume and O'Malley, n 6, 140. See also but compare C Waddell et al, "Treatment Decision-making at the End of Life: A Survey of Australian Doctors' Attitudes Towards Patients' Wishes and Euthanasia" (1996) 165(10) *Med J Aust* 540, 544.

¹¹ Vézina-Im et al, n 8, 34.

¹² Neil et al n 6, 724–725; Douglas, Kerridge and Ankeny, n 6, 393–395.

¹³ K Virik and P Glare, "Requests for Euthanasia made to a Tertiary Referral Teaching Hospital in Sydney, Australia in the Year 2000" (2002) 10(4) *Support Care Cancer* 309.

unrelievable pain,¹⁴ being a burden/dependent on others, lack of autonomy, control and independence, sense of hopelessness, social isolation,¹⁵ loss of dignity¹⁶ and anticipated suffering.¹⁷

This article examines cases involving unlawful assisted dying practices in one Australian State (Victoria) in the 12 months leading up to the commencement of the *VAD Act*. A small number of cases (nine) involving unlawful assisted dying practices were identified as part of a larger study of the incidence and nature of medical end-of-life decisions (ELDs) involving adult patients in Victoria.¹⁸ These nine cases are analysed to determine whether, if the *VAD Act* had been in operation at the relevant time, the patient would have been eligible to access VAD having regard to their capacity to request VAD and their potentially qualifying disease, illness or medical condition. This analysis may shed light on the extent to which unlawful medical practice may be avoided by the enactment of legislation that provides a lawful pathway for doctors to support patients who seek assistance to die when they are at the end of life.

II. METHODOLOGY

A. Study Design

A cross-sectional survey of Victorian doctors was conducted from May to September 2019. To maintain anonymity, the Australasian Medical Publishing Company (AMPCo) sampled the doctors, managed the sample database, and distributed the survey. An independent fieldwork agency managed the online survey, received, processed, and stored surveys, tracked completions, and supplied the de-identified dataset.

B. Data Sources/Measurement

¹⁴ Baume and O'Malley, n 6, 140; Kuhse et al, n 6; CA Stevens and R Hassan, "Management of Death, Dying and Euthanasia: Attitudes and Practices of Medical Practitioners in South Australia" (1994) 20(1) J Med Ethics 41, 45.

¹⁵ Virik and Glare, n 13, 311.

¹⁶ J Sahyouni, "Could Depression and Loss of Dignity Correlate with Requesting Euthanasia and Physician-Assisted Suicide? A Look at the Research from the United States, Canada, and the Netherlands" (Paper 9, Annual Celebration of Undergraduate Research and Creative Performance, 13 April 2018) <https://digitalcommons.hope.edu/curcp_17/9>.

¹⁷ L Radbruch et al, "Euthanasia and Physician-assisted Suicide: A White Paper from the European Association for Palliative Care" (2016) 30(2) Palliat Med 104, 116.

¹⁸ L Willmott et al, "Intentional Hastening of Death through Medication: A Case Series Analysis of Victorian Deaths Prior to the Voluntary Assisted Dying Act 2017" (2021) 51(10) Intern Med J 1650.

The survey was an English version of a survey originally developed by van der Maas et al in the Netherlands¹⁹ and used extensively elsewhere.²⁰ It was adapted to ensure suitability for the Australian context and to reflect our method (utilising database sampling and focusing on ELDs involving adults).²¹

The survey asked questions relating to the most recent death of an adult in the last 12 months for which the doctor was the treating or attending doctor. Questions identified the patient's illness, decisions concerning end-of-life care (including palliative care), and who was involved in these decisions (ie the patient, their substitute decision-maker, or medical staff). The survey focused on medical decisions that probably or certainly hastened the end of the patient's life or resulted in the patient's life not being prolonged, whether by withholding and/or withdrawing treatment(s) or using medication to increase pain or symptom relief. It also included information concerning practices of palliative or terminal sedation and voluntary stopping of eating and drinking. Survey questions addressed the reasons for the medical decision; whether the patient had capacity to request the medical act in question; the doctor's intention in making the decision; and the degree to which the patient's life was shortened by the decision, if at all.

C. Setting

Doctors received invitations to their postal and/or email address from the Medical Directory of Australia (MDA), maintained by AMPCo. Participants contacted by post could still complete the survey online as their letters included a personalised survey link. Three reminders were sent to non-responders via post and/or email at intervals of two to four weeks.

E. Participants

A random sample was drawn from the MDA of doctors who: (1) identified their main specialty as one of the 28 listed in Box 1; (2) had a Victorian primary practice address; and (3) were not from an earlier "wider sample". (The wider sample occurred because AMPCo initially recruited doctors from outside Victoria as well and these data could not be used.) A sample of 3,087 was drawn from 10,846 eligible doctors.

Box 1. Medical Specialties in Sample

1. Abdominal surgery
2. Breast surgery
3. Cardiology
4. Cardiothoracic surgery
5. Clinical haematology
6. Doctor-in-training

¹⁹ PJ Van der Maas et al, "Euthanasia, Physician-assisted Suicide, and other Medical Practices Involving the End of Life in the Netherlands, 1990–1995" (1996) 335(22) N Engl J Med 1699.

²⁰ F Riou et al, "When Physicians Report Having Used Medical Drugs to Deliberately End a Patient's Life: Findings of the 'End-of-life in France' Survey" (2015) 50(2) J Pain Symptom Manage 208; P Malpas, K Mitchell and H Koschwanez, "End-of-life Medical Decision Making in General Practice in New Zealand-13 Years On" (2015) 128(1418) NZ Med J 27; K Mitchell and G Owens, "End of life Decision-making by New Zealand General Practitioners: A National Survey" (2004) 117(1196) NZ Med J (Online) <https://www.researchgate.net/publication/8428915_End_of_life_decision-making_by_New_Zealand_general_practitioners_A_national_survey>; J Bilsen et al, "Changes in Medical End-of-life Practices during the Legalization Process of Euthanasia in Belgium" (2007) 65(4) Soc Sci Med 803; L Deliens et al, "End-of-life Decisions in Medical Practice in Flanders, Belgium: A Nationwide Survey" (2000) 356(9244) Lancet 1806; A Van der Heide et al, "End-of-life Decision-making in Six European Countries: Descriptive Study" (2003) 362(9381) Lancet 345; J Schildmann et al, "End-of-life Practices in Palliative Care: A Cross Sectional Survey of Physician Members of the German Society for Palliative Medicine" (2010) 24(8) Palliat Med 820; S Pennec et al, "End-of-life Medical Decisions in France" (2012) 494 Popul Soc 1; C Seale, "National Survey of End-of-life Decisions Made by UK Medical Practitioners" (2006) 20(1) Palliat Med 3; C Seale, "End-of-life Decisions in the UK Involving Medical Practitioners" (2009) 23(3) Palliat Med 198; I Marcoux et al, "Medical End-of-life Practices among Canadian Physicians: A Pilot Study" (2016) 4(2) CMAJ Open E222.

²¹ L Willmott et al, "Collecting Data on End-of-life Decision-making: Questionnaire Translation, Adaptation and Validity Assessment" (2021) Prog Palliat Care <<https://doi.org/10.1080/09699260.2021.1922795>>.

7. Emergency medicine
8. Endocrinology
9. Gastroenterology
10. General medicine/general physician
11. General practice
12. General surgery
13. Geriatric medicine
14. Gynaecological oncology
15. Immunology
16. Infectious diseases
17. Intensive care
18. Medical officer
19. Medical oncology
20. Neurology
21. Neurosurgery
22. Otorhinolaryngology
23. Palliative care
24. Radiation oncology
25. Renal medicine
26. Respiratory medicine
27. Urological surgery
28. Vascular surgery

F. Case Selection

Of the 3,087 doctors who were sent a survey, 358 returned a usable survey (response rate 11.6%). Potential cases involving assisted dying practices (the subject of this paper) were identified, consistent with previous studies²² by an affirmative response to the question: “was death the result of the use of medication prescribed, provided or administered by you or another doctor with the primary intention of hastening the end of the patient’s life (or enabling the patient to end their own life)?”. These cases (n = 12) were then assessed by LW, BW and RF, with input and agreement from KC, PY and GM, to ensure that survey responses as a whole reflected assisted dying practices (which by definition were unlawful as the survey directed participants to practice prior to the commencement of the Victorian legislation on 19 June 2019). This iterative process resulted in the exclusion of three cases in which the intention behind providing medication was unclear due to inconsistent or missing responses in those surveys.

G. Data Analysis

The first analysis of these cases (reported elsewhere)²³ examined commonalities and key themes across the cases that involved unlawful assisted dying practices. The second analysis (reported here) involved evaluating these cases against two key eligibility criteria in the *VAD Act*: the person’s decision-making capacity and medical condition. In relation to decision-making capacity, we analysed survey data concerning whether the person was considered by the doctor to have capacity. In relation to the person’s medical condition, we analysed the available information to determine whether the person’s condition was terminal, and whether death was expected within six months (or 12 months if the condition was neurodegenerative), as per the *VAD Act* eligibility criteria (see below).

Data relevant to assessing these two eligibility criteria for VAD were extracted and inserted into a table summarising the survey responses relevant to each criterion. While data extraction focused in particular on relevant survey questions, all responses in each survey were reviewed to better understand each

²² Kuhse et al, n 6; Van der Maas et al, n 19.

²³ Willmott et al, n 18.

individual case and the broader clinical picture, as well as to ensure that we considered the features of the case generally and whether or not they pointed to the patient satisfying these two criteria. The review of all responses for each case also enabled us to make some observations relating to the broader eligibility criteria other than decision-making capacity and medical condition.

H. Ethics Approval

The study was approved by the human research ethics committees at Queensland University of Technology, the University of Queensland and Vrije Universiteit Brussels. All participants provided informed consent by submitting a completed survey.

III. ALIGNMENT BETWEEN SELECTED VAD Act ELIGIBILITY CRITERIA AND SURVEY QUESTIONS

The purpose of the survey was to gather information about the incidence and nature of medical end-of-life decision-making in Victoria in the time leading up to the commencement of the *VAD Act*. The data collected from the survey also enabled some assessments to be made about whether the individual involved, had the VAD laws been in operation, may have been eligible to request VAD. In this section, we identify the relevant eligibility criteria from the *VAD Act*, explain the survey question(s) which elicit information that is relevant to the eligibility provision, and compare both to determine whether an assessment could be made about whether the individual would have been eligible to make a request for VAD.

The criteria for eligibility for VAD in Victoria are set out in s 9(1) of the *VAD Act*.²⁴ This states that:

- (a) the person must be aged 18 years or more; and
- (b) the person must –
 - (i) be an Australian citizen or permanent resident; and
 - (ii) be ordinarily resident in Victoria; and
 - (iii) at the time of making a first request, have been ordinarily resident in Victoria for at least 12 months; and
- (c) the person must have decision-making capacity in relation to voluntary assisted dying; and
- (d) the person must be diagnosed with a disease, illness or medical condition that –
 - (i) is incurable; and
 - (ii) is advanced, progressive and will cause death; and
 - (iii) is expected to cause death within weeks or months, not exceeding 6 months; and
 - (iv) is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable.

Section 9(4) of the *VAD Act* extends the timeframe until death in certain circumstances, providing that a person with a neurodegenerative condition may be eligible for VAD if death is expected within 12 months.

Accordingly, there are five main eligibility requirements in Victoria to access VAD. The first two criteria – that the person is an adult and has been a Victorian resident for at least 12 months – are satisfied or presumed satisfied in all cases reported in this survey. As the survey was designed to capture adult deaths only, and in all nine cases the adults who died were aged in their seventies, eighties or nineties, the age requirement that a person must be an adult²⁵ was clearly satisfied. The sample frame comprised doctors who practise in Victoria, so it is appropriate to assume that most, if not all, of those who died were Victorian residents. Although no data are available concerning the patient's ordinary place of residence, the length of time they had resided in Victoria, or their citizenship or permanent residence status, these

²⁴ These criteria are discussed in detail in BP White et al, "Comparative and Critical Analysis of Key Eligibility Criteria for Voluntary Assisted Dying under Five Legal Frameworks" (2021) 44(4) UNSWLJ 1663 and have been applied to a number of case studies in BP White et al, "Who is Eligible for Voluntary Assisted Dying? Nine Medical Conditions Assessed Against Five Legal Frameworks" (2022) 45(1) UNSWLJ 401, and J Hewitt et al, "Voluntary Assisted Dying in Victoria: Why Knowing the Law Matters to Nurses" (2021) 28(2) Nurs Ethics 221.

²⁵ *Voluntary Assisted Dying Act 2017* (Vic) s 9(1)(a).

are not relevant to the focus of the analysis, so for the purpose of this article, we assume that these criteria will be satisfied.

The fifth criterion of eligibility – that the condition is causing unacceptable suffering – is also excluded from analysis. Whether suffering can be relieved is a “subjective” assessment, assessed by the person, and the present survey responses are those of the medical practitioner, not the patient. With only the medical practitioner’s assessment, it is not possible to definitively state whether this criterion has been met.

The main focus of analysis here is on the third and fourth criteria of eligibility: whether the person has decision-making capacity relating to VAD; and whether the person has a relevant terminal disease, illness or medical condition (discussed in Part III(A) and (B) respectively). Some context is needed to understand the information derived from the survey in relation to these two aspects of eligibility. As explained above, the survey participant (doctor) was asked to identify their last adult patient who had died, and then answer questions about whether a medical decision had been made that contributed to the patient’s death.²⁶ In all nine cases considered in this article, the relevant medical decision – which the survey termed the “last mentioned act” – was the “use of medication prescribed, provided or administered by the participant or another doctor with the primary intention of hastening the end of the patient’s life (or enabling the patient to end their own life)”. The following sections set out the survey questions relevant to the “last mentioned act” and decision-making capacity and the patient’s illness.

A. Decision-making Capacity

Decision-making capacity is a key component of ensuring that a person’s decision to access VAD is their own. A person’s decision-making capacity is assessed at multiple points during the VAD process, including both eligibility assessments by doctors²⁷ and the final request for VAD.²⁸

Decision-making capacity is decision specific, which means that to be eligible for VAD, a person must have capacity to request VAD.²⁹ This requires a person to possess four abilities: to understand the relevant information, to retain that information, to use or weigh the information as part of a decision-making process, and to communicate their decision.³⁰ An adult is presumed to have decision-making capacity, unless it is demonstrated that they do not meet one of these four requirements.³¹

Relevant Survey Questions

Responses to one survey question in particular were relevant to considering whether the person had decision-making capacity to request assisted dying. This question, and possible responses, are set out in Table 1.

Table 1. Survey Questions Which Were Relevant to Assessing Whether the Person Had decision-making Capacity

Question Text	Relevant Response Options
Question 26 At the time of the decision about the last mentioned act, did the	<ul style="list-style-type: none">• yes;• no.

²⁶ Decisions that probably or certainly hastened the end of the patient’s life or resulted in the patient’s life not being prolonged included withholding or withdrawing a treatment or use of medication to increase pain or symptom relief.

²⁷ *Voluntary Assisted Dying Act 2017* (Vic) ss 16, 25.

²⁸ *Voluntary Assisted Dying Act 2017* (Vic) s 36. If VAD is provided by practitioner administration, capacity is also specifically assessed at the point of administration: *Voluntary Assisted Dying Act 2017* (Vic) s 64. This does not occur with self-administration.

²⁹ *Voluntary Assisted Dying Act 2017* (Vic) s 9(1)(c).

³⁰ *Voluntary Assisted Dying Act 2017* (Vic) s 4. How to evaluate whether these criteria are met is amplified in Department of Health and Human Services, Government of Victoria, *Voluntary Assisted Dying: Guidance for Health Practitioners* (Guide, July 2019) 34–36 <<https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying/coordinating-consulting-medical-practitioner-information>> (*Guidance for Health Practitioners*).

³¹ *Voluntary Assisted Dying Act 2017* (Vic) s 4(2).

patient have legal capacity to make a decision on the matter?	
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Alignment of Survey Questions with the Law

To be eligible for VAD, a person must have capacity to make decisions specifically to request VAD.³² In this paper, we have assumed that a response of “yes” to Q26 equated to the patient having decision-making capacity for VAD. However, there could be limitations to this approach.

The first limitation relates to the time at which capacity is assessed. The *VAD Act* stipulates that a person’s decision-making capacity is assessed at multiple points during the VAD process. However, in this survey, we were only seeking an assessment of capacity at the time a decision was made about the “last mentioned act”.

A second limitation was that in one case the survey responses were inconsistent.³³ In case 4, the relevant survey response stated that the patient had capacity. However, the response to the question about why the act hastening the end of life was not discussed with the patient stated that the patient was unconscious or semi-conscious and lacked capacity. How this inconsistency was treated during the analysis will be discussed later.

B. Terminal Disease, Illness or Medical Condition

Another core criterion of eligibility for VAD concerns the person’s disease, illness or medical condition.³⁴ To be eligible under the *VAD Act*, a person’s condition must be incurable, advanced, progressive and cause death, and that death must be expected to occur within six months (or 12 months for a neurodegenerative condition). Responses to three survey questions were examined to assess whether this eligibility requirement was satisfied. These questions, and possible responses, are set out in Table 2.

Table 2: Survey Questions Which Were Relevant to Assessing Whether the Person Had a Relevant Medical Condition

Question Text	Relevant Response Options
Question 11 What was the main cause of death?	<ul style="list-style-type: none"> • cancer; • heart disease; • neurodegenerative disease (Alzheimer’s, MND, Parkinson’s, etc); • cerebrovascular disease; • chronic respiratory disease; • diabetes mellitus; • renal disease; • influenza; • pneumonia; • accident (unintentional injuries); • intentional self-harm (suicide); • other (please specify); • unknown.
Question 22	<ul style="list-style-type: none"> • more than six months; • one to six months;

³² *Voluntary Assisted Dying Act 2017* (Vic) s 9(1)(c).

³³ Potential inconsistencies in the survey responses were discussed in Willmott et al, n 18.

³⁴ A person is not eligible to access VAD merely because they have a mental illness or a disability: *Voluntary Assisted Dying Act 2017* (Vic) s 9(2)–(3). However, a person with a disability or a mental illness is not precluded from accessing VAD if they meet the eligibility criteria: Ministerial Advisory Panel on Voluntary Assisted Dying, Department of Health and Human Services, Victoria State Government, *Final Report* (Report, 31 July 2017) (*MAP Report*). See MAP Report recommendation 5 in respect of mental illness: 80–82. See also MAP Report recommendation 6 in respect of disability: 83–85.

In your opinion, what is the estimated length of time the patient's life was shortened by the last mentioned act?	<ul style="list-style-type: none"> • one to four weeks; • one to seven days; • less than 24 hours; • life was probably not shortened at all.
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In addition to the responses to the above questions, in two cases, further detail relevant to this eligibility requirement was provided in comments at the end of the survey. In one instance, the survey respondent specifically stated that the person had an incurable condition: "patient has incurable metastatic cancer." The other case referred to a patient with renal disease receiving dialysis.

Alignment of Survey Questions with the Law

The medical condition criterion of eligibility for VAD comprises three components. A person must have a medical condition that is incurable; is advanced and progressive; and is expected to cause death with six months (or 12 months if the condition is neurodegenerative). Each of these requirements will be considered in turn.

First, whether a person suffers from a disease, illness or medical condition that is "incurable"³⁵ is an "objective test based on available medical treatments".³⁶ If there is a "clinically indicated treatment that will cure the disease",³⁷ then a person's condition is not incurable, even if the person refuses to have that treatment. However, if clinically indicated treatment will only manage the symptoms of disease, but cannot cure it, then the person has an "incurable" disease.³⁸ Some of the response options to the cause of death question are clearly "incurable" conditions, such as Alzheimer's disease or diabetes. Other response options are generally considered "curable", such as influenza and pneumonia. A third group of response options may be curable or incurable, depending on the stage of the person's disease progression and the availability of treatment options (eg, in cancer). Finally, the survey information does not contain detail as to whether the patient's current condition was a result of the disease progression, or a result of the patient's refusal of potentially curative treatment.³⁹ Consequently, responses to cause of death alone may not provide sufficient information to determine whether the person has an incurable condition.

Second, to be eligible for VAD in Victoria, a person's disease, illness or medical condition must be "advanced and progressive".⁴⁰ This means the person's condition must be in an active and continuing state of decline or deterioration,⁴¹ and the condition must be at an advanced stage along its expected trajectory. Ultimately, both these requirements involve assessments of degree, but they combine to indicate that access to VAD is only available to people in the latter stages of a terminal condition. There were no survey questions that specifically related to this component, although in one case relevant information was obtained from the comment at the end of the survey.⁴² However, useful information as to whether the person's condition was "advanced" was obtained from responses to the estimated length of time by which the patient's life was shortened (discussed below). In six out of the nine cases, the person's life was estimated to have been shortened by less than a week, providing a clear indication that their condition was indeed "advanced" and was progressing towards imminent death.

³⁵ *Voluntary Assisted Dying Act 2017* (Vic) s 9(1)(d)(i).

³⁶ Victoria, *Parliamentary Debates*, Legislative Counsel, 21 November 2017, 6218 (Gavin Jennings).

³⁷ Explanatory Memorandum, *Voluntary Assisted Dying Bill 2017* (Vic) cl 9.

³⁸ Explanatory Memorandum, *Voluntary Assisted Dying Bill 2017* (Vic) cl 9.

³⁹ Under the *Voluntary Assisted Dying Act 2017* (Vic), "incurable" is objectively determined, and does not include conditions which may be treated but where the patient has refused the treatment. See White et al, "Comparative and Critical Analysis of Key Eligibility Criteria for Voluntary Assisted Dying Under Five Legal Frameworks", n 24.

⁴⁰ *Voluntary Assisted Dying Act 2017* (Vic) s 9(1)(d)(ii).

⁴¹ *Guidance for Health Practitioners*, n 30, 37.

⁴² The patient was noted to have "incurable metastatic cancer" (Case 6). Metastatic cancer is, by definition, cancer which has spread to other parts of the body, demonstrating that the disease has progressed. By their nature, cancers continue to spread, unless effective treatment is available to halt the process, and in this case the cancer was noted to be "incurable".

Finally, to be eligible for VAD, a person's medical condition must be expected to cause death within six months,⁴³ or 12 months if the condition is neurodegenerative.⁴⁴ It is recognised that prognosis is not an exact science, so meeting this criterion requires clinicians to estimate the remaining time until death.⁴⁵ In evaluating this timeframe, clinicians must take into account the person's individual situation, including their condition and comorbidities, and whether the person refuses treatment that is available.⁴⁶ Responses to the cause of death question directly addressed this component, by estimating the length of time that the patient's life was shortened by the last mentioned act. In all cases considered, the response was sufficiently specific to provide an accurate answer whether or not the patient was in the later stages of a terminal condition.⁴⁷

IV. RESULTS

All nine cases involved elderly adults, in their seventies, eighties or nineties. There was balance across genders: five patients were male and four were female. Six patients died in hospital⁴⁸ (including four in hospital palliative care⁴⁹), two in residential aged care,⁵⁰ and the remaining one died in a hospice.⁵¹ No patients died at home.

None of the deaths were reported as being sudden or totally unexpected. Patients presented with serious medical conditions in all cases: four patients had cancer,⁵² two patients had renal disease,⁵³ two had heart disease⁵⁴ and one had chronic respiratory disease.⁵⁵ These medical conditions would enable patients to qualify for VAD, provided they applied at a sufficiently advanced stage in the progression of their illness, and death was expected to occur within six months. Only one case in this sample involved a patient whose death was not expected to occur within six months.⁵⁶

In all nine cases, treatment in the week prior to the decision concerning the "last mentioned act" was focused on comfort or palliation, rather than cure or the prolongation of life.⁵⁷ All patients received

⁴³ *Voluntary Assisted Dying Act 2017* (Vic) s 9(1)(d)(iii).

⁴⁴ *Voluntary Assisted Dying Act 2017* (Vic) s 9(4).

⁴⁵ *Guidance for Health Practitioners*, n 30, 38.

⁴⁶ Explanatory Memorandum, *Voluntary Assisted Dying Bill 2017* (Vic) cl 9.

⁴⁷ It was possible that the answers to this survey question would not provide sufficient detail if the patient was suffering from a neurodegenerative condition and was expected to live for "more than six months" (given that the *Voluntary Assisted Dying Act 2017* (Vic) extends the timeframe until death for people with a neurodegenerative condition to 12 months). However, the answers given in the sample were sufficiently specific to enable the eligibility of the person's medical condition to be accurately determined. The only case involving a person with "more than 6 months" to live was a woman with renal disease (Case 1), who was therefore clearly ineligible. The only case involving a person with neurodegenerative disease was a woman with dementia who was estimated to have one to four weeks to live (Case 9), thus meeting the terminal condition criterion.

⁴⁸ Cases 2, 4, 5, 6, 7, 8.

⁴⁹ Cases 5, 6, 7 and 8.

⁵⁰ Cases 3 and 9.

⁵¹ Case 1.

⁵² Cases 3, 5 and 6. Case 9 had dementia and cancer.

⁵³ Cases 1 and 7.

⁵⁴ Cases 2 and 4.

⁵⁵ Case 8.

⁵⁶ Case 1, involving a patient with renal disease.

⁵⁷ Responses to the question about the main treatment focus during the last week before death.

palliative care, either in hospital,⁵⁸ in residential aged care⁵⁹ or in the community.⁶⁰ The duration of palliative care ranged from only in the last few days,⁶¹ to a month,⁶² or 214 days in one case.⁶³

The decision about the “last mentioned act” was made by the patient in five cases, at their request (n = 3), or with their express or implied consent (n = 2).⁶⁴ In four cases, this decision was made by the patient’s substitute decision-maker, either at their request (n = 1), or with their express or implied consent (n = 3). Doctors frequently discussed the probable or certain hastening of the end of life by this act with the patient’s partner and/or family (n = 6) and/or the patient (n = 4). Where there was no discussion with the patient, this was generally because they lacked capacity, specifically that they were unconscious or semi-conscious (n = 3), delirious/confused (n = 2) and/or had dementia (n = 2). Doctors frequently discussed the probable or certain hastening of the end of life with health care professional(s) specialised in palliative care (n = 7) and medical colleagues (n = 5). Six doctors reported having this discussion with multiple people.

The majority of cases (seven out of nine) combined withholding or withdrawing treatment with the administration of life-ending medications. Five cases involved withholding or withdrawal of antibiotics or other medications,⁶⁵ one also included the withdrawal of intravenous fluids.⁶⁶ In one case the patient refused surgery,⁶⁷ another refused nutrition and hydration,⁶⁸ and a final case involved withholding dialysis.⁶⁹ All the ELDs discussed in the nine sample cases involved the administration of morphine or other opioids (often in combination with a benzodiazepine).

Suffering was not a contentious issue. Although the surveys were completed by doctors, and thus provided evidence of the doctor’s perception of suffering or the patient’s reported suffering, rather than the patient’s subjective experience of suffering as required by the *VAD Act*,⁷⁰ serious suffering was a reason given for the action taken in eight out of the nine cases.⁷¹ In six cases, the doctor mentioned “serious physical suffering”,⁷² in four cases “serious psychological suffering” was noted,⁷³ and eight cases mentioned “expected future suffering” (doctors could select multiple response options).⁷⁴

The survey data were less conclusive on the question of decision-making capacity. Five cases involved a person with capacity,⁷⁵ and in a further three cases, the patient lacked capacity.⁷⁶ However, in the

⁵⁸ Cases 2, 4, 5, 6, 7 and 8.

⁵⁹ Cases 3 and 9.

⁶⁰ Case 1.

⁶¹ Cases 2, 4, 7 and 10 days in Case 6.

⁶² Cases 1, 3, 5 and 8.

⁶³ Case 9.

⁶⁴ The survey instrument distinguished between *requesting* the “last mentioned act” and *consenting* to it, reflecting the different nature of a request for life to end via an act and consenting to an act that would bring about that outcome.

⁶⁵ Cases 2, 4, 6, 8 and 9.

⁶⁶ Case 2.

⁶⁷ Case 6.

⁶⁸ Case 1.

⁶⁹ Case 7.

⁷⁰ *Voluntary Assisted Dying Act 2017* (Vic) s 9(1)(d)(iv) requires that a person’s medical condition “causing suffering to the person that cannot be relieved in a manner that *the person considers* tolerable” (emphasis added).

⁷¹ Responses to the question about the most important reasons to proceed with the last mentioned act.

⁷² Cases 1, 2, 5, 7, 8 and 9.

⁷³ Cases 3, 5, 7 and 8.

⁷⁴ Cases 1, 2, 3, 4, 5, 7, 8 and 9.

⁷⁵ Cases 1, 3, 5, 7 and 8.

⁷⁶ Cases 2, 6 and 9.

remaining case, the data were inconclusive, as contradictory responses to survey questions were received.⁷⁷ Accordingly, it was not possible to reach definitive conclusions about capacity (and therefore eligibility) in all cases.

Part IV(A) below sets out cases identified from the survey data where a decision was made with the primary intention of hastening a person's death, but the person would likely *not* have been eligible to request VAD if the *VAD Act* had been operational in Victoria at the time of the decision. Part IV(B) then considers cases where a patient would likely have been eligible to request VAD if the *VAD Act* had been in operation at the relevant time.

A. Survey Cases in Which the Patient Was Likely to Have Been Ineligible to Request VAD

Five cases from the present sample involved decisions which were made with the intention of hastening the end of the patient's life, and involved patients who, either certainly (four cases) or probably (one case) would not have satisfied the eligibility criteria of the *VAD Act*. In three cases, the patient was described as lacking decision-making capacity, and being unconscious or semiconscious, delirious or confused, or having dementia. In the fourth case, whether the patient had capacity is unclear, because contradictory information about decision-making capacity was recorded, but the fact that the person was described as "unconscious or semi-conscious and lacking capacity" suggests the patient may have been incompetent at the time of the "last mentioned act". The fifth case involved a patient who had capacity but would have been ineligible for VAD because the person had a medical condition (renal disease) that was not likely to cause death within six months. Table 3 summarises the key features of each of these cases.

Table 3. Cases in Which Patient Likely to Have Been Ineligible to Request VAD

	Patient	Decision	Life Shortened by	Capacity	Medical Condition	Overall Eligibility
1	Female with renal disease (90–99 years), died in a hospice	Withholding and withdrawing of nutrition and hydration Administration of morphine and/or other opioids* Deep sedation for 1–2 weeks right up until death	More than six months	Yes Patient had capacity at the time of the decision	No Unclear whether renal disease was at an incurable, advanced and progressive stage Condition was not expected to cause death within six months	No Death was not expected within 6 months
2	Male with heart disease (80–89 years), died in hospital	Withholding treatment Withdrawing medication and IV fluids Administration of morphine and/or other	One to seven days	No Patient was unconscious or semi-conscious, delirious or confused, had dementia and lacked capacity	Probably Main cause of death was heart disease (almost certainly incurable) Patient's life was shortened by one to seven	No Patient did not have capacity

⁷⁷ In Case 4, responses were contradictory, stating both that the patient had capacity and that they were unconscious or semi-conscious and lacked capacity.

		opioids and benzodiazepines Palliative sedation			days, so condition was likely advanced, progressive, and expected to cause death within six months	
4	Female with heart disease (90–99 years), died in hospital	Withholding medication Withdrawing treatment Administration of morphine and/or other opioids Deep sedation for one to seven days right up until death	One to seven days	Unclear, probably no Contradictory responses: decision not discussed with patient because patient was unconscious or semi-conscious and lacked capacity Also said patient had capacity at the time of the decision	Probably Main cause of death heart disease (almost certainly incurable) Patient's life was shortened by one to seven days, so condition was likely advanced, progressive, and expected to cause death within six months	Probably no Capacity is unclear, but responses suggest patient may not have had capacity
6	Male with metastatic cancer (80–89 years), died in hospital palliative care	Withholding antibiotics and surgery Withdrawing antibiotic treatment Administration of morphine or other opioids, and benzodiazepine Deep sedation for one to seven days right up until death	One to seven days	No Patient was delirious/confused and lacked capacity	Probably Condition described as “incurable metastatic cancer”. Metastatic cancer is advanced and progressive. Patient's life was shortened by one to seven days, so condition was expected to cause death within six months Note withholding and withdrawing treatment may have shortened	No Patient did not have capacity

					the patient's prognosis	
9	Female with dementia and cancer (90–99 years), died in residential aged care facility	Withdrawing cancer medication Administration of morphine or other opioids and benzodiazepine Deep sedation for one to two weeks right up until death	One to four weeks	No Patient was unconscious or semi-conscious, had dementia and lacked capacity	Unknown Main cause of death dementia, not cancer Patient's life shortened by one to four weeks.	No Patient did not have capacity Disease was probably advanced and progressive Unclear if death was expected within 12 months (the prescribed time period for neurodegenerative conditions) without withdrawal of treatment

* The question about the “last mentioned act” states that death was the result of the administration of prescribed medication “with the primary intention of hastening the end of the patient’s life (or enabling the patient to end their own life)”. Because this is the same for every case, we have just stated which medications were administered in the table, without repeating the intention of hastening the patient’s death.

B. Survey Cases in Which the Patient Was Likely to Have Been Eligible to Request VAD

Four cases involved decisions to hasten the end life and involved patients who, either certainly (two cases) or probably (two cases) would have been eligible to request VAD under the *VAD Act*. All four cases involved a patient with decision-making capacity. Two patients had advanced cancer, one had renal disease and one had chronic respiratory disease. In three of the four cases, the patient’s death was expected within seven days, which strongly suggests that their condition was advanced, progressive and would cause death within the six-month timeframe stipulated in the *VAD Act*.

Table 4. Cases in Which Patient Would Likely Have Met the Eligibility to Request VAD

	Patient	Decision	Life Shortened by	Capacity	Medical Condition	Overall Eligibility
3	Male with cancer (70–79 years), died in residential aged care facility	Administration of morphine or other opioids Described as “palliative or terminal sedation”	One to seven days	Yes Patient had capacity at the time of the decision	Yes Main cause of death cancer. Patient’s life was shortened by one to seven days, so it appears cancer was incurable, advanced, progressive and likely to cause death within six months	Yes Patient had capacity Patient had advanced cancer and death was expected within one to seven days
5	Female with cancer (80–89 years), died in hospital palliative care	Administration of morphine or other opioids and benzodiazepine	<24 hours	Yes Patient had capacity at the time of	Yes Main cause of death cancer. Patient’s life was shortened by under 24 hours, so it	Yes Patient had capacity Patient had advanced

				the decision	seems cancer was incurable, advanced, progressive and likely to cause death within six months	cancer and death was expected within 24 hours
7	Male with renal disease (80–89 years), died in hospital palliative care	Withholding dialysis and withdrawing treatment Administration of benzodiazepine and higher than necessary doses of morphine or other opioids	One to six months	Yes Patient had capacity at the time of the decision	Probably Patient on dialysis so assume end stage kidney failure – incurable, advanced, progressive Disease was likely to cause death within six months as patient's life shortened by one to six months*	Probably Patient had capacity Patient probably had an eligible medical condition
8	Male with chronic respiratory disease (70–79 years), died in hospital palliative care	Withholding antibiotics Administration of benzodiazepine and higher than necessary doses of morphine or other opioids Deep sedation for days right up until death	One to seven days	Yes Patient had capacity at the time of the decision	Probably Chronic respiratory disease (unknown if it was incurable, advanced, progressive). However, because death was expected in one to seven days, it may be assumed the patient's condition satisfied these criteria.	Probably Patient had capacity Patient probably had an eligible medical condition

* It is not stated whether one to six months was the patient's life expectancy before the decision to stop dialysis, or after the decision to stop dialysis. However, because most patients die within one to two weeks after stopping dialysis, it can be assumed that this referred to the patient's prognosis before deciding to withdraw treatment.

V. DISCUSSION

In this section, we consider the implications for these ELDs, now that VAD is lawful in Victoria and Western Australia, and will soon be lawful in Tasmania, South Australia, Queensland and New South Wales. First, we consider whether the patients in these cases would be eligible to request VAD, and conclude that many would not, primarily because they lack decision-making capacity. Further, in many of the cases analysed, the decision leading to the person's death was made in the last seven days of a person's life, which might make VAD practically less feasible as an alternative in those cases where the patient would be eligible. Finally, we consider the implications of the fact that sedation was used in all nine cases reported, before outlining limitations of this study.

A. Would Patients in These Cases Be Eligible to Request VAD?

All cases involved decisions made by or on behalf of adults who were suffering due to a serious disease, illness or medical condition. All cases involved medical conditions that would meet the VAD eligibility criteria if the person requested VAD at a sufficiently advanced stage in the trajectory of their illness (which most were) and within an estimated six months until death. In only one case in the present sample

would these conditions not be likely to be satisfied: in case 1, a patient with renal disease sought assistance to hasten the end of her life when she was estimated to have more than six months to live.⁷⁸

In five cases, that the patient had capacity to make a choice about the “last mentioned act” was not in doubt.⁷⁹ In one case (case 4), the survey provided contradictory evidence. Although the doctor clearly stated that the patient had capacity, the doctor also reported that the probable or certain hastening of the end of life by the “last mentioned act” was not discussed with the patient because the patient was unconscious or semi-conscious and lacked capacity. In the final three cases, as described in Table 3, the patient lacked decision-making capacity. The introduction of VAD laws will not provide choice to the patients in these cases where decision-making capacity was not present.

We reiterate that the deaths in all nine cases occurred outside the law as the practices described occurred before VAD was lawful in Victoria. However, even if the *VAD Act* had been implemented at the time, the patients in more than half of the cases described would not have been eligible to request VAD (as they were ineligible on the ground of lacking decision-making capacity or were not expected to die within six months). This research suggests that end-of-life medical decisions are likely to continue to occur outside the law (whether or not VAD is lawful), as is the case in jurisdictions around the world.⁸⁰ More research is needed to determine the incidence and causative factors of this.

B. Timing of End-of-life Decision

In addition to the fact that VAD will only be possible in cases where the patient retains decision-making capacity, the stage and progression of the patients’ medical conditions in these cases suggests that VAD would not have been a practical option for the patient, had they requested it. In most cases, the decision to hasten the patient’s death was taken very close to the person’s anticipated death. Five cases occurred within the last week of the person’s life,⁸¹ and one was less than 24 hours before death.⁸² In only two cases was the decision taken with more than a month until death.⁸³

While it is possible to proceed with the VAD process in an expedited manner in some cases,⁸⁴ VAD is a procedurally complex process, involving formal assessments of eligibility by two separate medical practitioners and an application for an administration permit.⁸⁵ In Victoria, only 25% of VAD applications have proceeded from first to final request in under 11 days,⁸⁶ and there are no statistics on applications which have been processed in a shorter timeframe. In view of these procedural limitations, it seems likely that decisions to hasten the end of a person’s life will continue to be made in hospital and residential aged care settings outside the VAD framework. This reinforces the need for research into and better regulation of these practices.

⁷⁸ Case 1.

⁷⁹ Cases 1, 3, 5, 7 and 8.

⁸⁰ See, eg, A van der Heide et al, “End-of-life Decisions in the Netherlands over 25 Years” (2017) 377 N Engl J Med 492.

⁸¹ Cases 2, 3, 4, 6 and 8.

⁸² Case 5.

⁸³ Cases 1 and 7.

⁸⁴ *Voluntary Assisted Dying Act 2017* (Vic) s 38(2) allows the nine day waiting period between first and final requests to be waived where the person’s death is likely to occur before the expiration of that time limit.

⁸⁵ As to the procedural complexity of the VAD process, see BP White et al, “Does the Voluntary Assisted Dying Act 2017 (Vic) Reflect Its Stated Policy Goals?” (2020) 43(2) UNSWLJ 417, 441–443. Empirical research into the operation of the Victorian system has also identified challenges with its procedural complexity and the time taken to access voluntary assisted dying: B White et al, “Prospective Oversight and Approval of Assisted Dying Cases in Victoria, Australia: A Qualitative Study of Doctors’ Perspectives” (2021) BMJ Support Palliat Care (Online) <<https://spcare.bmj.com/content/early/2021/05/24/bmjspcare-2021-002972>>; L Willmott et al, “Participating Doctors’ Perspectives on the Regulation of Voluntary Assisted Dying in Victoria: A Qualitative Study” (2021) 215(3) Med J Aust 125.

⁸⁶ Voluntary Assisted Dying Review Board, Victoria State Government, *Report of Operations: July to December 2020* (February 2021) 9.

C. Medical Decisions about Administration of Morphine and Deep Sedation

Of particular note is that in all nine cases, the medication was administered to sedate the patient.⁸⁷ Four cases involved palliative sedation.⁸⁸ In five cases, the patient was placed in a state of continuous deep sedation until death.⁸⁹ The length of time under deep sedation varied from under 24 hours in one case⁹⁰ to one to two weeks in two cases.⁹¹ According to the doctrine of double effect,⁹² placing a patient in deep sedation or administering morphine or other opioids to a patient at the end of life can be lawful if the primary purpose is pain relief or symptom control, even if the doctor considers that this will shorten the person's life.⁹³ However, in all nine cases in this study, medication was administered with the *primary* intention of hastening the patient's death, rather than merely providing relief from symptoms.⁹⁴ Further, in three of these cases, the doctor specifically reported using a higher dose of morphine than was necessary for symptom relief.⁹⁵ As mentioned earlier, these nine cases represent clearly unlawful conduct.⁹⁶

In a further two of the nine cases, deep sedation occurred where the patient was not imminently dying, for the primary purpose of bringing the person to death. In the case of a woman suffering renal disease who had more than six months to live, this was performed at the explicit request of the patient.⁹⁷ It was also performed on an elderly woman with dementia and cancer who was estimated to have one to four weeks to live, without her consent (she lacked capacity) but at the request of her substitute decision-maker.⁹⁸ While the specific time until expected death was not clear in this latter case (one week would be quite different from four weeks in terms of causing death), if terminal sedation requested by a person's substitute decision-maker is causing the person's death, this is deeply troubling. The relative frequency of these practices points to a need to research and investigate how palliative and deep sedation are being practised in Australia.

D. Limitations

A limitation of this study is the survey's low response rate, and the small case size of nine patients.

A more significant limitation is that some survey responses provided potentially ambiguous information. This may be due to limitations of the survey, doctors' interpretation of survey questions and/or the research team's interpretation of those answers. As described above, one case provided directly contradictory data relating to decision-making capacity, which is a key criterion of eligibility.⁹⁹

⁸⁷ This issue is discussed further in Willmott et al, n 18.

⁸⁸ Cases 2, 3, 5 and 7.

⁸⁹ Cases 1, 4, 6, 8 and 9.

⁹⁰ Case 8.

⁹¹ Cases 1 and 9.

⁹² B White and L Willmott, "Double Effect and Palliative Care Excuses" in B White, F McDonald and L Willmott (eds), *Health Law in Australia* (Lawbook, 3rd ed, 2018).

⁹³ Note however this systematic review which found that deep sedation does not shorten life: EM Beller et al, "Palliative Pharmacological Sedation for Symptom Relief in Terminally Ill Adults" (2015) 1(1) Cochrane Database of Syst Rev CD010206 <<https://pubmed.ncbi.nlm.nih.gov/25879099/>>.

⁹⁴ Question 21.

⁹⁵ Cases 4, 7 and 8.

⁹⁶ See B White, L Willmott and M Ashby, "Palliative Care, Double Effect and the Law in Australia" (2011) 41(6) Intern Med J 485.

⁹⁷ Case 1.

⁹⁸ Case 9.

⁹⁹ Answers provided in relation to Case 4 provided contradictory answers to two survey questions concerning capacity. See Part III(C).

A third limitation is that the survey questions were designed with end-of-life decision-making generally in mind, not specifically contemplating the potential applicability of the *VAD Act*. Because of this, as explained in Part III, the survey did not ask questions which enabled conclusive determination of two of the eligibility criteria for VAD (capacity and medical condition). For Australian citizenship and Victorian residence, eligibility was presumed. Because a person's suffering is subjectively assessed, there were insufficient data to determine whether the person met the criterion. Accordingly, the analysis in this article focused on two criteria – decision-making capacity and whether a person had an eligible medical condition.

VI. CONCLUSION

In conclusion, the sample of nine cases analysed in this article demonstrate that deliberate decisions to end a patient's life are occurring outside the law. This analysis provides insight into the extent to which the availability of VAD may have prevented unlawful assisted deaths. Although the sample described here predates the commencement of the *VAD Act* in Victoria, not all of the patients in these cases would have been eligible to request VAD had the legislation been in operation at the time. As has previously been observed in relation to cases involving suicides of chronically and terminally ill people, and cases involving prosecution of family members or friends for assisted suicide and mercy killing,¹⁰⁰ some of these regrettable circumstances may be avoided by the passage of VAD legislation permitting a person to receive assistance to die, but many will not.

The main reason why the patients in our sample would not have been eligible to request VAD was that the patients lacked capacity, whereas under the *VAD Act* a person making a request for VAD must have decision-making capacity. Further, there will be cases, like case 1 in the present sample, where the person wishes to end their life outside the six-month timeframe stipulated in the *VAD Act*. Additionally, the majority of these cases involved patients in their last week of life, making it very likely to be too procedurally challenging to access VAD as an alternative.

Because there will continue to be instances of ELDs which do not fall within the scope of the *VAD Act*, cases likely those described in this article may continue to occur in practice. The cases described in this paper all involved the use of sedation at the end of life in some form or another. Some involved continuous deep sedation until death, and some involved sedation with the primary intention of hastening death. Accordingly, there will continue to be a need to research and regulate other practices at the end of life, particularly palliative and deep sedation.

¹⁰⁰ Del Villar, Willmott and White, n 6.