

Voluntary Assisted Dying & Palliative Care

As of June 19 2019 adults in Victoria with an advanced, progressive, incurable illness expected to cause their death within 6 months (or 12 months in the case of a neurodegenerative disorder, like MND) are able to seek assessment for eligibility to access voluntary assisted dying (VAD).

This is a completely new feature of our health care landscape and will challenge many of us at a personal and organisational level. The legalisation of VAD adds a further layer of complexity to our previously well-established end-of-life care practices, but one that we should not, and indeed, cannot ignore, regardless of our personal views about the practice. It will take some time for VAD to become embedded and better understood, but my strong personal view is that we need not fear nor shun it in palliative care practice. It is, after all, a legally available, and for a minority of our patients, valid end-of life option that they might wish to take if they have reached the limits of their suffering despite our very best efforts.

There are, of course, many misunderstood aspects of this legislation and some clarification is required at this early stage of implementation.

The VAD Act prohibits any health care professional, in the course of their care of a patient, to suggest VAD or raise its possibility with a patient. The patient must make an explicit request for information about VAD before a further discussion can occur. Important guidance in this potentially tricky area is available at:

<https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying/health-practitioner-information>

Importantly, for a person to be eligible for VAD, he/she needs to have decision-making capacity (with respect to VAD) from the time of their formal first request right up until their death, if they choose to proceed to administration of the VAD medication. It is also important to note that no-one can make a request on behalf of another person, and that a request for VAD cannot be made in an advanced care directive.

The two doctors (the **coordinating** and the **consulting medical practitioners**) who conduct the independent patient eligibility assessments, must also both be satisfied that the person is making a consistent request and with no coercion. They must, under the Act, ensure that the patient understands the full consequences of their decision and that all other management options, including palliative care, are discussed. At all key stages of the VAD process, it must be reiterated to the patient that she/he can withdraw from the process at any stage, even once they have access to the VAD medication.

It is also important to understand the two different VAD permits that the coordinating medical practitioner can apply for (the doctor holds the permit, not the patient). The term “voluntary assisted dying” incorporates two different, but related end of life practices. In my experience, this is an area that creates a considerable amount of confusion for both the public and health practitioners.

Firstly, a patient can be prescribed a lethal dose of medication to be self-administered orally, or in some circumstances, via a feeding tube (e.g PEG tube). This is often called “physician assisted dying” particularly in some USA jurisdictions. In these cases, expected to be the majority in Victoria, the coordinating medical practitioner applies for a **self-administration permit**, and once prescribed the patient decides when (or whether) to take possession of the medication, and when (or whether) to take it. The patient must take the medication themselves but others can assist with the preparation of the liquid. After self-administration of this 100mls of liquid (a powder mixed with liquid immediately prior to administration) the patient will soon become very sleepy, become comatose within 10 to 15 minutes, and die on average 30-40 minutes after administration.

Secondly, and only if the patient is unable to physically take, swallow or absorb the oral medication, the doctor can apply for a **practitioner administration permit** and only the coordinating medical practitioner can administer this medication at a time that is mutually convenient. The patient does not get to choose

freely between these 2 options, rather it is a decision made after assessment and discussion with the patient about their ability to self-administer. Administration, by another person (under our law, the coordinating doctor) of a lethal dose of medication, at the express and consistent request of a competent patient, is commonly known as “voluntary euthanasia” in overseas jurisdictions where this is legal. This is where it can be a bit confusing but important to understand.

If the coordinating medical practitioner is granted a **practitioner administration permit** then he/she can administer the VAD medication in one of two ways. Most likely the VAD medication (actually a series of consecutively administered medications, completely different to the oral preparation) will be given intravenously, by “push” injections via a peripheral cannula, not by “a drip”, as is commonly reported in the media. This will bring about the virtually immediate death of the patient. In some very occasional circumstances, eg a MND patient with a PEG tube who is incapable of self-administration and does not want IV access, the “oral” preparation of VAD medication can be administered via the PEG tube, but only by the coordinating medical practitioner.

After the patient’s death by VAD, the formal, legal process is little different to when a patient dies of an expected disease without accessing VAD (ie the vast majority of our patients). The death certificate has to be completed within 48 hours as usual, and by a doctor (not necessarily the coordinating doctor) who can attest to the manner and cause of death. The doctor does not need to attend the place of death but must be comfortable to sign the certificate.

I suspect that in practice, the coordinating doctor, who will likely have quite a close relationship with the patient and family by the end, will choose to attend and/or sign the death certificate. There is now a new section of the electronic death certificate that asks the certifying doctor to state, that if he/she is aware that the deceased was the subject of a VAD permit, the manner of the death, eg patient died without taking the VAD medication, the patient died by self-administration, or the patient died by practitioner administration of the VAD medication. The “cause of death” is written as the underlying disease from which the patient was suffering and which was the reason for the VAD permit being granted.

The doctor also needs to notify the Coroner’s office by telephone that the death has occurred, but it is not a “reportable death” under the Coroner’s Act. For confidentiality reasons, the final death certificate copy sent to the family (and a public document) will only show the underlying cause of death and not mention VAD.

As time goes by I’m sure that we, in palliative care, will all become more comfortable with discussing VAD with patients and their families/carers, whether we agree with their decision or not. In fact it is my hunch that the introduction of this legislation will actually have an enhancing effect on our end-of-life conversations and might bring to light many unexplored concerns that patients often have in the advanced stage of their illness. It is highly likely that many patients will decide not to proceed down the VAD pathway once we explore and hopefully successfully address these concerns. However for those who do wish to proceed, for those who just cannot suffer any longer, then we should continue to care and, if we cannot help them ourselves, then we should find someone who can.

Dr Greg Mewett

Palliative Care Physician

Member of VAD Implementation Taskforce

CONTACTS

Grampians Regional Palliative Care Team

Ph 5320 3553 Fax 5320 6493

Central Grampians Palliative Care

Ph 5352 9328 Fax 5352 9425

Gandarra Palliative Care Unit

Ph 5320 3895 Fax 5320 3763

Ballarat Hospice Care Inc

Ph 5333 1118 Fax 5333 1119

Djerriwarrh Palliative Care

Ph 5367 2000 Fax 5367 4274

Grampians Region Palliative Care Consortium

Ph: 0428 737 330

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