

# Voluntary Assisted Dying (VAD) in Victoria: Comparing reasons for applying with Canada and Oregon

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# Introduction

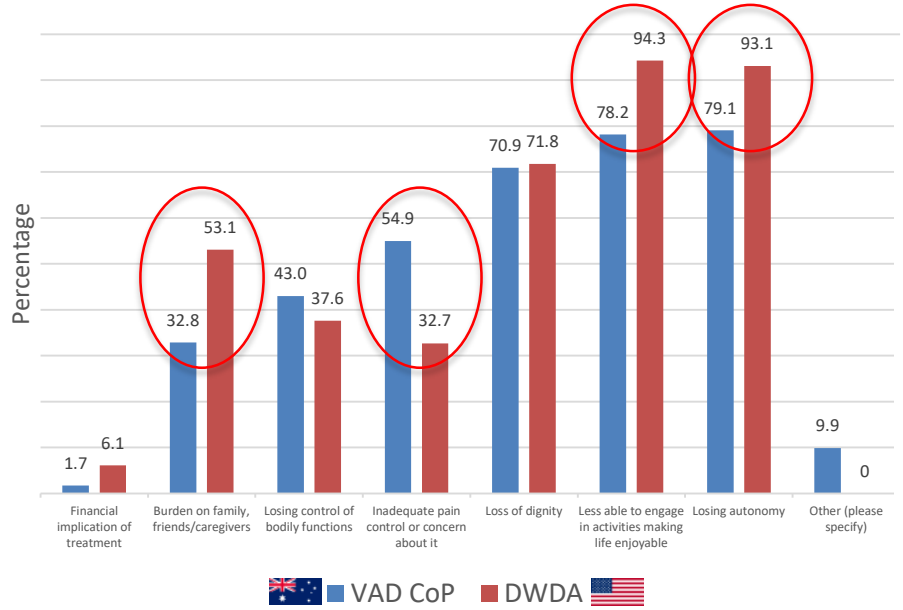
- Victorian VAD Community of Practice (VAD CoP)
  - online forum for VAD-trained doctors
  - 39 of 234 VAD-trained and registered doctors
- Reasons for applying for VAD required when registering a patient (Oregon system)
  - Losing autonomy
  - Less able to engage in activities making life enjoyable
  - Loss of dignity
  - Losing control of bodily functions
  - Burden on family, friends/caregivers
  - Inadequate pain control or concern about it
  - Financial implication of treatment
  - Other (please specify)
- Victorian VAD Review Board Report of Operations
  - Most recently published in August with data from January to June 2021
  - Reasons for applying not included
  - Data from VAD *applicants*
- Oregon 
  - Dying with Dignity Act (DWDA)
  - Longest-running assisted dying legislation in the world
  - Same method of data capture of reasons for applying
  - Data from *recipients*
- Canada 
  - Medical Assistance in Dying (MAiD)
  - Largest assisted dying jurisdiction in the world (7,595 deaths in 2020)
  - Different method of data capture of reasons for applying
  - Data on *recipients*

# Methods

- Analysis of submitted deidentified case data from members of the Victorian VAD Community of Practice (CoP)
- Monash University HREC Project ID: 24804, dated 19/5/2020, modified 8/10/2020
- Reasons for applying analysed and compared to DWDA and MAiD data  
- Chi square analysis: the reasons for accessing VAD would be similar to the reasons for accessing DWDA (α = 0.01)  
- Statistical comparison to MAiD data not possible due to differences in data capture; descriptive/numerical comparison only 

# Results – Reasons for applying

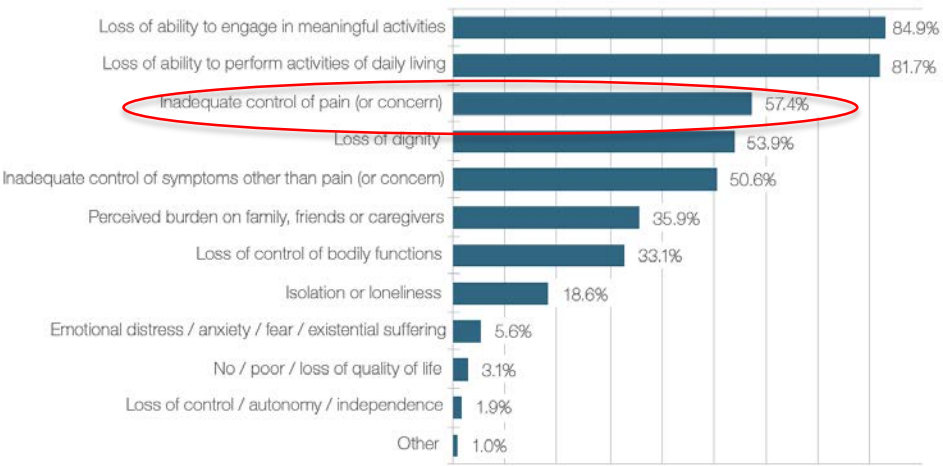
Reasons for applying for assisted dying





$\chi^2 (6, N = 344) = 108.77, p < .001$



Nature of suffering of MAiD recipients, 2020



# Questions raised

- Difference due to VAD CoP population as “applicants” vs DWDA and MAiD “recipients”?
- Cultural differences?   
- Differences in access to supportive care?   
- Appropriateness of current categories?
  - PCOC symptoms and problems more appropriate / common language
- Qualitative methodology would likely yield rich results in this area