VADSA Position Statement: Prognosis as an Unreliable and Unjust Barrier to Voluntary Assisted Dying in Australia

The reliance on prognosis as an eligibility criterion within Australian voluntary assisted dying (VAD) legislation is fundamentally flawed and operates as an unjust barrier to access. While intended as a safeguard, prognostic thresholds are inherently unreliable and inconsistently applied, resulting in inequitable exclusion of patients experiencing intolerable suffering.

In all states in Australia, VAD laws require that a person's condition is expected to cause death within a defined timeframe—generally **6 months, or 12 months for neurodegenerative conditions**. This requirement is embedded in state legislation such as the *Voluntary Assisted Dying Act 2017 (Vic)* and equivalent laws in South Australia, Western Australia, Tasmania, New South Wales, and Queensland[1]. However, the clinical task underpinning this requirement—prognostication—is widely recognised as uncertain and imprecise. The *Medical Journal of Australia* explicitly describes estimating life expectancy for VAD as an "inherently uncertain and imprecise" process, shaped by variability in disease trajectories and limitations in predictive tools.

This uncertainty undermines the ethical legitimacy of using prognosis as a gatekeeping mechanism. Prognostic estimates are derived from population-level data and probabilities, not certainties about individual patients. As Nahm, Stockler, and Kiely argue, "prognosis is inherently uncertain" and difficult to operationalise within rigid legislative criteria. Consequently, patients with comparable levels of suffering may be treated differently depending on whether a clinician feels sufficiently confident in predicting death within a specified timeframe. This creates arbitrary distinctions that are not grounded in patient need, but in the limitations of medical prediction.

In practice, prognosis does not merely function as a clinical assessment but as a structural barrier. Evidence from Australian VAD implementation indicates that some patients are deemed ineligible not because their suffering is less severe, but because clinicians cannot certify a sufficiently short life expectancy. In South Australia, for example, it is acknowledged that many individuals may not receive a qualifying prognosis at all, either due to uncertainty or clinician reluctance, leading some to incorrectly assume they are ineligible. This reflects a broader systemic issue: access to VAD is contingent not only on patient condition, but on the subjective confidence of clinicians interpreting uncertain prognostic criteria.

The ethical consequence is a shift away from the core justification for VAD—relief of intolerable suffering—toward an unreliable temporal threshold. This undermines respect for autonomy by denying competent individuals the ability to make decisions about their own dying based on their lived experience. Instead, access is determined by whether their illness conforms to legislatively defined timelines that may not reflect clinical reality.

Furthermore, requiring clinicians to make definitive prognostic judgments introduces inconsistency and moral burden. As Australian scholars have noted, eligibility criteria based on phrases such as "expected to cause death within 6 months" lack clarity and rely heavily on subjective interpretation, leading to variability in decision-making and potential inequities in access. This inconsistency is incompatible with principles of fairness and transparency in healthcare law.

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[1] The ACT – the most recent jurisdiction to pass VAD legislation in 2024 - removed the time limit on prognosis.

In conclusion, prognosis is an unreliable and ethically problematic foundation for determining eligibility for voluntary assisted dying in Australia. Its inherent uncertainty creates arbitrary and inequitable barriers, limits patient autonomy, and shifts the focus away from suffering—the central moral concern. Reform of Australian VAD frameworks should prioritise patient-centred criteria over rigid prognostic thresholds, ensuring that access is guided by compassion, equity, and clinical reality rather than uncertain predictions of life expectancy.

Optional reference list (APA style)

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