

Health, Social Care and Sport Committee  
Scottish Parliament

4 December 2024

**RE: Stage 1 Scrutiny of the Assisted Dying for Terminally Ill Adults (Scotland) Bill,  
request for further evidence**

Dear Committee members,

I am writing in relation to the Stage 1 consideration of the Assisted Dying for Terminally Ill Adults (Scotland) Bill.

I was invited to provide evidence to the committee on Tuesday 5 November 2024 but was unfortunately unable to attend. I have been invited to provide my views in writing and have been asked to address specific questions related to the mandatory training that participating health practitioners (eligible doctors, and nurses in some jurisdictions) must complete in Australia. Having managed the delivery of the training programs in Victoria, Western Australia and Queensland, my answers will focus on these three states.

**Overview of the training**

The training in all three states is designed to be completed in approximately 6 hours. The training consists of eLearning modules, hosted on a Learning Management System. While the number of modules varies from state to state, the training curriculum includes:

- an introductory module addressing the background to legalising assisted dying; key terminology; and an overview of the legal process;
- one to two contextual modules which detail other end-of-life options; best practices for conversations at the end of life, including cultural considerations; conscientious objection; how to have conversations about assisted dying; and how to prioritise self-care;
- five to six modules on the legal process to access assisted dying, including patient requests; the eligibility criteria and eligibility assessments; steps related to the administration of the medication; and legal offences and protections;
- an assessment module consisting of 30 multiple-choice questions to assess practitioners' understanding of the content of the training.

The following research papers provide additional information on the development of the Victorian training, and participation in the training by Victorian doctors.

White, B.P., Willmott, L., Close, E., Hewitt, J., Meehan, R., Greaves, L.L., Parker, M.H. and Yates, P., 2021. Development of voluntary assisted dying training in Victoria, Australia: a model for consideration. *Journal of Palliative Care*, 36(3), pp.162-167.

Willmott, L., Feeney, R., AM, P.Y., Parker, M., Waller, K. and White, B.P., 2024. A cross-sectional study of the first two years of mandatory training for doctors participating in voluntary assisted dying. *Palliative & supportive care*, 22(4), pp.674-680.

### **Level of resource provided to develop the training initially, and on an ongoing basis**

The approach to develop and manage the training varies between different Australian jurisdictions. In some jurisdictions, the training was developed internally, while other jurisdictions engaged a third-party organisation to develop the training via a request for tender process. Similarly, some Health Departments host and manage the training themselves, whilst others use a third-party to host the training and support users.

From my experience working on the Victorian, Western Australian and Queensland training, I can provide the following general information in relation to resourcing for these training programs:

- the training in these states took between 6 and 9 months to develop;
- the project team consisted of:
  - an academic team (experts in assisted dying and end-of-life law) to lead the project
  - several legal writers to draft the content
  - a clinician to review all drafts from a clinical perspective
  - a project manager
- the Health Department reviewed all drafts, provided feedback, guidance and final approvals;
- professional peak bodies and stakeholders were invited to review the content and provide feedback on early versions of the modules;
- a designer was engaged to convert the content into interactive eLearning modules, and a videographer was engaged to produce several short training videos;
- the training went live before the law became operational to give practitioners some time to complete the training;
- as the training is hosted online, it is necessary to have an IT team to support users and rectify any 'glitches';
- training revisions have been implemented to address user feedback and updates to policies.

### **How coercion is assessed, and how it is addressed in the mandatory training**

In all Australian jurisdictions where assisted dying is legal, a person's request for assisted dying must be made voluntarily and without coercion. This requirement is assessed by two independent medical practitioners during the eligibility assessments. It is also assessed at other steps in the request and assessment process (including at the final review, and time of administration, although this varies from state to state). If the assessing practitioner finds that the person is not making the decision voluntarily, they must assess the person as ineligible.

The mandatory training covers the eligibility criteria, including coercion, extensively. Relevant training content includes:

- guidance on how to assess coercion, including questions to ask the patient and family members/carers to help detect coercion;
- links to screening tools and studies;
- learning activities such as case studies and multiple-choice questions, to reinforce learning.

In relation to the other questions put forward by the committee, I can only provide some general comments as these are outside my area of expertise.

**In relation to how assisted dying operates in Australia**, this varies significantly from state to state. In Victoria for instance, assisted dying is predominately subsumed within existing private services (predominantly General Practice). In Queensland however, where the Health Department issued a Health Service Directive in relation to assisted dying, the majority of patients access assisted dying via the public sector.

For further information on the Queensland model, see: White, B.P., Ward, A., Feeney, R., Greaves, L.L. and Willmott, L., 2024. Models of care for voluntary assisted dying: a qualitative study of Queensland's approach in its first year of operation. *Australian Health Review*.

**Heavy workload**, and inadequate remuneration have been reported as system issues and disincentives for health practitioners to participate in the service. For further information, see:

Haining, C.M., Willmott, L., Towler, S. and White, B.P., 2023. Access to voluntary assisted dying in Australia requires fair remuneration for medical practitioners. *The Medical Journal of Australia*, 218(1), p.8.

Go Gentle Australia, National Voluntary Assisted Dying Survey 2023.

[GGA NationalVADSurvey\\_Report\\_A4\\_DIGITAL.pdf](#)

**Complications in the context of self-administration commonly refers to variations in time from administration to death.** In this situation, health professionals in most Australian jurisdictions are not permitted to administer any assisted dying medication. They should, however, provide appropriate measures to keep the patient comfortable. These requirements are briefly covered in the mandatory training.

In Tasmania, patients are required to complete a final permission in which they state their wishes in relation to steps to be taken in case of *unexpected complications* (for both practitioner administration and assisted self-administration).

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## Additional resources

### **Development of Voluntary Assisted Dying Training in Victoria, Australia: A model for consideration**

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#### **Author Disclosure Statement**

**Conflicts of Interest:** Lindy Willmott, Ben White, Patsy Yates and Malcolm Parker were engaged by the Victorian Government to design and provide the legislatively mandated training for doctors involved in voluntary assisted dying described in this article. Jayne Hewitt was the project manager for this training project and Rebecca Meehan, Laura Ley Greaves and Eliana Close were employed on the project. All contributed to the design of the training. Lindy Willmott is also a member of the Board of Palliative Care Australia, but this article only represents her views. Rebecca Meehan is also an employee of Queensland Parliament, but this article only represents her views.

**Funding:** Although the training was funded by the Victorian Government, this article was written without recourse to project funds or support.

**Research Ethics:** Ethics for the focus group was approved by Queensland University of Technology Human Research Ethics Committee (approval number 1800001268) on 23/01/2019 and University of Queensland Human Research Ethics Committees A & B (clearance number 2019000135) on 23/01/2019.

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## **Abstract**

### **Background**

Voluntary assisted dying was legalised in Victoria, Australia in June 2019, and was the first jurisdiction internationally to legislatively mandate training for doctors conducting eligibility assessments of patients. Mandatory training was designed as a safeguard to ensure compliance within the system, so that only eligible patients would gain access to voluntary assisted dying.

### **Objective**

This article outlines the development of training mandated for doctors prior to undertaking eligibility assessments for voluntary assisted dying. The training addressed required legal knowledge, including doctors' roles, duties and legal protections, and also provided instruction on relevant clinical skills.

### **Design**

Training design was based on two main principles: to comprehensively impart the legal duties imposed by the legislation; and to be readily accessible for busy doctors. The law was first mapped into a curriculum, and circulated to medical colleges, societies and professional organisations as well as international experts for feedback. The training was converted into an online e-learning format and tested at a focus group of doctors.

### **Results**

The training comprises nine modules including an assessment module. While the predominant focus of the modules is on law, they also contain some clinical components and links to further resources. Modules also contain videos, case studies and interactive exercises.

The assessment consists of 30 questions, selected randomly from a question bank, with a pass mark of 90%.

### **Conclusion**

The Victorian legislatively-mandated voluntary assisted dying training provides standardised baseline knowledge to enhance the quality and consistency of decision-making by doctors.

While further evaluation of this training is needed, it may provide a model for other jurisdictions considering making voluntary assisted dying lawful.

### **Key words**

Voluntary assisted dying; medical training; mandatory training; curriculum and training design; end of life law; end of life decision-making

## Introduction

In June 2019, the Australian state of Victoria joined a growing number of jurisdictions internationally that permit voluntary assisted dying (VAD). The Victorian law permits a competent adult, with an incurable, advanced and progressive condition, that is expected to cause death within 6 months (12 months for neurodegenerative conditions), to request a doctor to prescribe (or in limited circumstances, administer) a medication that will cause death.<sup>1</sup> To be eligible for VAD, the person's condition must also cause suffering that cannot be relieved in a way they regard as tolerable. The request for VAD must be voluntary and enduring.

During the Victorian Parliamentary debates, the State's Premier, Daniel Andrews, touted the proposed law as the most conservative model in the world, containing 68 safeguards.<sup>2</sup> As one of its safeguards, the *Voluntary Assisted Dying Act 2017* (Vic) included an 18-month implementation period before it started operation in June 2019. This time was to allow for the establishment of infrastructure to support the safe and effective operation of the law.<sup>3</sup> The legislation also stipulates training for doctors who choose to participate in VAD (and who are eligible, based on specified requirements of experience and expertise). The Victorian law is the first in the world to require doctors to receive training about the VAD law prior to assessing patients' eligibility.<sup>4</sup> This is significant internationally, in both the context of VAD and in clinical practice, where training is typically left to the discretion of medical schools, professional bodies, and health institutions.

The requirement for mandatory training originated from the Ministerial Advisory Panel established to advise the Victorian Government on the content of VAD legislation. The Panel deemed training necessary because the eligibility criteria were new and an established body of practice did not exist in Victoria.<sup>5</sup> Consequently, it recommended that the training

‘comprise of obligations and requirements under the legislation’, to ensure that doctors ‘can undertake high-quality assessments of a person’s eligibility for voluntary assisted dying.’<sup>6</sup> It was also imperative that training be ‘easily accessible’ so patients’ access to VAD was not unduly delayed while doctors completed it.<sup>6</sup>

As more jurisdictions legalise VAD, the need to educate doctors and health practitioners about the law and policy is gaining more attention.<sup>3,7</sup> In Canada, Ball et al. report in relation to the provincial medical college’s effective referral policy that ‘[p]hysician misinformation and misunderstandings have led to patients being misinformed about location options, process and even procedure eligibility’.<sup>8</sup> Hogg et al. surveyed Canadian health practitioners and identified gaps in their knowledge of the law, with a majority (64%) of respondents expressing interest in further training.<sup>9</sup> A lack of knowledge about the law not only affects patients, but can leave doctors and health practitioners feeling unprepared to manage conversations about VAD.<sup>9</sup> Surveys on the attitudes of Australian and New Zealand geriatricians,<sup>10</sup> and Australian medical oncologists<sup>11</sup> on the legalisation of VAD also emphasised doctors’ desire for greater certainty about the boundaries of eligibility criteria.

Despite the recognised need for education as part of VAD implementation, there is little published about VAD legal training or the process of developing it. We located only two studies which described the process of developing training for VAD, both from Canada.<sup>12,13</sup> Furthermore, much of the implementation literature in VAD jurisdictions focuses on wider issues such as developing clinical guidelines,<sup>14</sup> hospital programs<sup>15</sup> or programs to provide direct support to doctors.<sup>16</sup> Examples of these programs include the Life End Information Forum (LEIF) for doctors in Belgium, and Support and Consultation on Euthanasia in the Netherlands (SCEN). While LEIF and SCEN doctors must undergo further training to become members of these groups, most of the literature focuses on the outcomes of that education, rather than on how the training was developed.<sup>17,18</sup>



This paper addresses this gap and outlines the design and delivery of the VAD legal training for Victorian doctors. As more jurisdictions contemplate enacting VAD laws and the safeguards that are needed, this new model of mandatory legal training and how it could be developed are likely to receive increasing consideration.

## **Design process**

### *Establishment*

Our team, with expertise in law (LW, BW), nursing (PY), medicine and bioethics (MP) successfully tendered to the Victorian Government to develop and deliver the VAD training. The team had previous experience in design and delivery of palliative care education and training (PY) and legal education for doctors (BW, LW) and medical students (MP) about end-of-life law. Project staff appointed had qualifications in law (JH, EC), medicine (LLG), nursing (JH) and allied health (EC, RM). The relevant government department, the Victorian Department of Health and Human Services (DHHS), and the Implementation Taskforce that oversaw the introduction of the VAD framework and this project, had regular input throughout the development of the training.

### *Principles informing design*

Informed by the Ministerial Advisory Panel's recommendations, training design was based on two main principles. The first was the need for doctors to understand the range of new obligations imposed by the legislation so as to promote consistent and high-quality decision-making in carrying out their legislative duties. While the focus of the training was on the legal requirements of the Act rather than clinical challenges inherent in its application, the training also needed to highlight relevant clinical skills, in particular, decision-making capacity assessments and screening for potential abuse. The second principle was the need for the training to be readily accessible. Under the Victorian law, a doctor must successfully

complete the training before undertaking a VAD eligibility assessment for a patient. Undue delay in accessing training could adversely affect the ability of a person seeking VAD to be assessed as eligible.

### *Developing training content*

Informed by these principles, the project team developed both legal and clinical content. As part of that process, we consulted with several international experts and reviewed publicly-available online materials from Canada.<sup>19</sup> These strategies were particularly helpful in identifying useful resources for clinical practice, and instructional tools suitable for busy doctors.

A first draft of the training modules was circulated to 18 relevant medical colleges, societies and professional organisations as well as international experts (including doctors and researchers) for feedback.

An e-learning designer converted the written curriculum into interactive online modules, hosted in a custom-designed learning management system.

### *Focus group testing*

These interactive online modules were tested with a focus group of doctors who had variable knowledge of the Victorian legislation (n=7). The doctors worked through the modules and completed a random selection of multiple-choice questions developed as part of the assessment module. Focus group test results ranged from 68% to 100% and helped inform the level of difficulty required to ensure a rigorous assessment process. Participants were also surveyed to evaluate the training, and their feedback resulted in further clarification of the law and improved functionality of the learning management system. Ethics approval was granted for this focus group testing from two University ethics committees (details above).

## Content, delivery and operation

### *Content*

After the iterative process described above, and ongoing input from the DHHS and the Implementation Taskforce, the training was finalised into nine online modules (see Table 1). While the training is primarily focused on providing doctors with knowledge of their obligations under the legislation, additional resources in each module provide clinical guidance. For example, Module 4 focuses on VAD eligibility assessments and contains clinical resources about decision-making capacity, coercion and elder abuse. The clinical material is self-paced, allowing doctors to spend time on areas where they perceive that they need further guidance.

**Table 1: Voluntary Assisted Dying (VAD) Training Modules**

<b>Module</b>	<b>Title</b>
Course Introduction	This module describes how to navigate through the online training, and what is required to successfully complete the training.
1	Introduction (describing the nature of the VAD system and how it is different from other care provided at the end of life)
2	Conversations, a first request, and [medical practitioners] deciding whether to participate in VAD
3	Roles, qualifications and expertise of medical practitioners
4	VAD eligibility assessments by the co-ordinating medical practitioner and the consulting medical practitioner
5	From assessments of eligibility for VAD to a VAD permit

<b>Module</b>	<b>Title</b>
6	Prescribing or administering VAD medications and actions following the patient's death
7	Protections [for medical practitioners and others] and oversight
8	Assessment
9	Self-care for medical practitioners, glossary and resources

*Note: The term 'medical practitioner' rather than doctor is used as the module titles reflect the terminology in the Voluntary Assisted Dying Act 2017 (Vic).*

Several design techniques aimed to encourage interactive learning. The modules contain videos on salient clinical issues including capacity assessments and discussing the process with the patient. Clinical case studies were also included to demonstrate some of the legal processes. Formative quizzes and other interactive tools also allowed participants to engage in active learning. Reflective exercises at multiple points prompted doctors to reflect on their practice including any need for further training or education. Finally, the learning management software allowed users to only progress through the content incrementally, to ensure adequate engagement.

The online training is intended to take approximately six hours to complete. This length was chosen to ensure that the training is rigorous, but can still be completed within a manageable time frame. It was available from 16 April 2019, approximately two months before the legislation commenced operation, reducing the potential delay for patients waiting to access VAD.

#### *Face to face training*

To supplement the online training, members of the project team (LW, BW, JH and RM) also facilitated a one-day face-to-face training session in Melbourne, Victoria prior to a State-

endorsed implementation conference one month before the legislation commenced. This face-to-face training was based on the online modules and involved the input of two medical specialist co-presenters with extensive experience in palliative care, one also with expertise in VAD in Canada.

### *Assessment*

Having completed the training, doctors must pass the assessment before qualifying to evaluate patient eligibility for VAD. The assessment consists of a stratified random sample of 30 multiple-choice questions, drawn from a pool of 90. It is stratified so that doctors' knowledge across all modules is assessed. Given the significance and gravity of this new medical practice, it was critical to ensure a high level of competency in the training material. A passing score of 90% was established after consultation with the Implementation Taskforce, the DHHS and focus group participants. Doctors are provided up to five attempts to pass the assessment. Following two unsuccessful attempts they are locked out of the assessment module for 24 hours, to provide time to review the training content.

### *Evaluation*

This mandated training is the first of its kind, and feedback on its content and functionality is imperative to ensure that it meets doctors' learning needs and to determine areas for improvement. After successfully completing the assessment, doctors are invited to complete an optional evaluation survey. The survey contains multiple-choice questions, Likert scale questions, and opportunities to provide qualitative feedback. There is not scope to include survey data in this paper (it will be reported in future) but evaluation of the efficacy of the training will be critical. As such, the implications discussed below may need to be qualified accordingly.

### **Implications of the Victorian model of training**

As jurisdictions around Australia and the world contemplate legalising VAD, they must consider the implications of these significant changes for the health workforce. This includes the need for adequate training for the doctors and health practitioners who will ultimately be responsible for the provision of VAD. There are three significant implications of the Victorian model of mandated training, which suggest it may be a model for other jurisdictions to consider.

### *State-endorsed VAD training*

It is significant that the Victorian training is delivered on behalf of, and endorsed by, the State. Prior to assessing eligibility for VAD, doctors are required to undertake training that is ‘approved’ by the relevant Government official.<sup>20</sup> The training design was overseen by both the DHHS and Implementation Taskforce, with regular input from both groups. Three consequences flow from this being ‘State-endorsed training’.

The first is that there is State control over the content and scope of knowledge that doctors must possess. To this extent, the Government decides the minimum level of mandatory training. The second consequence is that the training has the approval of the State, which is significant because such training necessarily involves interpreting how the legislation is applied in practice. Having the weight of the State behind such views gives an authority to the training that is not present if provided by a hospital, health service or medical college. From a regulatory perspective, such training is therefore also an important vehicle to shape how the law is implemented in practice. Thirdly, State-endorsed training provides a consistent level of baseline knowledge. This VAD training provides consistent information throughout Victoria, across practice-settings and specialties, which would not be achieved if it were created and delivered by hospitals, health services or other organisations such as medical colleges. This is not to say these other organisations do not have a critical role in

providing VAD training. Historically, they are a common source of clinical training and we anticipate that more clinically-oriented training will be developed through these traditional avenues over time to supplement the legal focus of the mandatory training.

#### *VAD training's role as a safeguard*

The second important feature of the training is its role as a legislated safeguard. For VAD laws to operate fairly and efficiently, knowledge of the law, the processes it establishes and the duties it imposes are critical. In reports and parliamentary debates preceding enactment of the law in Victoria, VAD training was stated as a key safeguard to support the safe and effective operation of the system. The Ministerial Advisory Panel noted it provides assurance to the community that assessments will be undertaken consistently, and also provides participating doctors with certainty that they are appropriately interpreting the legal framework.<sup>6</sup>

We note that in other jurisdictions, knowledge of VAD laws has been identified as a challenge<sup>9,21</sup> with calls for more professional education.<sup>9,21,22</sup> Indeed, this is consistent with findings about deficits in legal knowledge in other areas of end-of-life law.<sup>23,24,25</sup> A mandated and standardised training program can ensure baseline knowledge of the VAD laws.

It is important, however, to be realistic about what such training can achieve. There are competing considerations that must be weighed in developing a course. It must be rigorous but also accessible. A comprehensive week-long face-to-face training program may arguably produce higher levels of knowledge than the current course. But it would also mean that fewer doctors would practically be able to undertake the training. This would have adverse implications for patients who may struggle to find a doctor who has undertaken the required training. Moreover, there is necessarily some degree of expertise that must be developed over time through clinical experience with VAD.

As with other fields of clinical practice, when doctors consider further expertise or training is needed to safely practise they should be proactive in ensuring their competence. The function of this training is to provide baseline knowledge of the VAD laws, but this should be complemented by other training for doctors who want and need it. We endorse wider training for doctors participating in VAD and observe that such training has been developed in other jurisdictions after VAD was legalised.<sup>16,17</sup> It is important to note, however, that the minimum level of knowledge established by the required VAD training is higher in Victoria than elsewhere in the world where training is not mandated. By appropriately balancing rigour with accessibility, the training aims to work effectively as a safeguard, without creating an access barrier for patients.

#### *Training prior to VAD becoming lawful*

A third implication of this model of VAD training is that it was created and launched during a planned 18-month implementation period prior to the law commencing operation. This period provided an opportunity for staged development of the training resources and scope for input from key stakeholders. As part of a wider implementation process, the training was situated in the broader work undertaken by the DHHS, including the development of clinical guidance and other materials to support doctors. This is in contrast to the recent experience of VAD (or medical assistance in dying as it is called) in Canada. The law was passed without a formal implementation period, and any training was left to local health services.<sup>26</sup>

If VAD legislation is passed in other jurisdictions and mandatory training is required, it is imperative that designing and developing this training is prioritised immediately during any implementation period. An 18-month period is desirable given the complexity of developing the training, along with the time that is needed to seek input from relevant stakeholders.

#### **Conclusion**



Designing the Victorian VAD training was challenging. It required translating a complex and challenging law into the clinical setting in a way that is meaningful for doctors.<sup>3</sup> This exercise required high level legal knowledge of a complex law, an understanding of the end-of-life clinical setting and expertise in medical education and training. The experience in Victoria of designing legislatively-mandated VAD training is instructive for other jurisdictions. Western Australia has just passed its *Voluntary Assisted Dying Act 2019* (WA) which includes a requirement for participating doctors to undertake similar training. It is anticipated that this approach will continue in other Australian States that are considering reform such as Queensland and South Australia where active parliamentary inquiries are underway. Other countries may also consider adopting such an approach when introducing their laws. Furthermore, governments may wish to consider implementing such training in jurisdictions where VAD is already lawful. Even if not legislatively-mandated, the process of State-endorsed formal training which provides standardised baseline levels of knowledge can enhance the quality and consistency of decision-making.

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# A cross-sectional study of the first two years of mandatory training for doctors participating in voluntary assisted dying

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**Abstract**

**Objectives.** Voluntary assisted dying (VAD) was legalized in Victoria, Australia, in June 2019. Victoria was the first jurisdiction in the world to require doctors to undertake training before providing VAD. This study examines data from doctors who completed the mandatory training in the first 2 years of the VAD system's operation (up to 30 June 2021). It describes the doctors who are undertaking VAD training, their post-training attitudes toward VAD participation, and their experiences of the mandatory training.

**Methods.** Through the online training, doctors completed a short demographic survey and undertook formal assessment of knowledge (90% pass mark). They also were invited to complete an optional survey evaluating the training.

**Results.** In total, 289 doctors passed the training, most commonly males (56%) aged 36–65 years (82%) from an urban location (72%). Most were more than 10 years post fellowship (68%) and practising as general practitioners (51%) or medical oncologists (16%). The training most commonly took 6 h (range 2 h to over 9 h). Most doctors passed the assessment at the first (65%) or second (19%) attempt. Almost all participants (97%) found the training helpful or very helpful and most reported being confident or very confident in their knowledge (93%) and application (88%) of the VAD legislation.

**Significance of results.** Doctors reported the training was helpful and improved their confidence in knowing the law and applying it in clinical practice. The profile of trained doctors (particularly their location and specialty) suggests continued growth of participating doctors is needed to facilitate patient access to VAD. It is important that this safeguard does not discourage doctors' participation.

**Introduction**

There is a growing international trend to legalize voluntary assisted dying (VAD) (White and Willmott, 2018). This includes in Australia where, over the last 4 years, VAD has been legalized in five of its six States: Victoria, Western Australia, Tasmania, South Australia, and Queensland. The term VAD is used in Australia to refer to euthanasia and physician-assisted dying, though different terminology is used elsewhere in the world.

When contemplating reform, law-makers must be satisfied there are sufficient safeguards to ensure only eligible individuals can access VAD. One safeguard which is now an established part of the Australian VAD model is legislatively-mandated training of health professionals prior to assessing eligibility for VAD or providing it [Department of Health and Human Services, 2017; Western Australia Voluntary Assisted Dying Bill, 2019; Voluntary Assisted Dying Act, 2021 (SA)].

Mandated training aims to ensure that health professionals are familiar with their legal duties (Department of Health and Human Services, 2017). This ensures standardized baseline knowledge, improving the quality and consistency of health professionals' decision-making and the safety of the system (White et al., 2021). These Australian training programs include an assessment module which must be passed, providing a formal means of ensuring competence.

While VAD training occurs internationally, there is variability in the degree to which it is formalized. The Netherlands and Belgium have programs which provide training for doctors who act as independent second consultants in euthanasia requests (Van Wesemael et al., 2009; Cohen et al., 2014). These doctors receive training in palliative care, relevant law, and patient communication skills (Van Wesemael et al., 2009; Cohen et al., 2014). In Canada, training is available through professional development (Ding et al., 2019), including education provided

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by the Canadian Medical Association and the Canadian Association of Medical Assistance in Dying Assessors and Providers.

Research from Belgium and the Netherlands suggests that training is beneficial, and may improve the quality of euthanasia consultations (Jansen-van der Weide et al., 2007; Van Wesemael et al., 2009; Cohen et al., 2014). There are calls for expanded and more formalized training of doctors in Canada (Hogg et al., 2018; MacDonald et al., 2018) and Belgium (Cohen et al., 2014) particularly for junior doctors (Ding et al., 2019), and as part of undergraduate and postgraduate medical education for all health professionals (Downar and Francescutti, 2017; Brown et al., 2020). Some Canadian commentators suggest that training and education should focus more on regulatory aspects of medical assistance in dying (Downar et al., 2018; MacDonald et al., 2018; Ding et al., 2019).

Victoria was the first Australian state to legalize VAD. Its mandatory training was developed during an 18-month implementation period, and became available approximately 2 months prior to the legislation commencing (White et al., 2021). This ensured some doctors would be trained (a legal requirement to be involved in VAD in Victoria) when the law started operation, differing from other jurisdictions such as Belgium and Canada where VAD legalization preceded systematic training efforts (Van Wesemael et al., 2009; Downar et al., 2018).

As more jurisdictions contemplate enacting VAD laws, the need to educate doctors (and other health professionals) about law and policy, and how best to do this, is becoming increasingly prominent (Fujioka et al., 2019; White et al., 2019). This paper describes the early experience in Victoria of the world's first legislatively-mandated VAD training for doctors. It reports on who has undertaken and passed the training and is therefore eligible to participate in VAD, and their willingness to perform various VAD roles. We also describe participating doctors' observations on the training, and their post-training confidence in knowing and applying the VAD legislation. This work was not a formal evaluation of the mandatory training.

## Methods

### Training content and delivery

The VAD training is provided in an online e-learning format and comprises nine modules including an assessment module. The design and development process, and training content, delivery and operation have been reported elsewhere (White et al., 2021). The training focuses on the legal requirements of the VAD law including doctors' roles, duties, and legal protections. Content also includes relevant clinical skills, particularly decision-making capacity assessments and screening for potential abuse. Each module links to additional clinical resources. Training is intended to take approximately 6 h to complete.

Doctors must pass the assessment comprising 30 multiple-choice questions, drawn from a bank of 90 questions. The pass mark is 90% and doctors have five attempts to pass the assessment. Training completion is registered in the learning management system when a doctor has completed the online modules and successfully passed the assessment. After completing the training, doctors are invited to answer an optional cross-sectional post-training survey.

### Study design

We examined responses from the post-training survey along with data collected during training and assessment (demographic questions and assessment results). We identified characteristics of doctors who undertook and passed the training. We also examined the experience and attitudes of participants regarding the training.

### Setting

This study draws on data from the first 2 years of VAD operation (19 June 2019 to 30 June 2021). This includes doctors who completed the training prior to 19 June 2019 as the training was available from 15 April 2019.

### Inclusion criteria

The training can only be completed by medical specialists, including vocationally registered general practitioners, who are eligible to participate in VAD in Victoria. We retrospectively identified all doctors who undertook the training in the specified timeframe. For inclusion in the study, doctors had to have completed the training and passed the assessment.

### Data sources/measurement

The principal data source was the post-training survey comprising 14 questions on training content and functionality. Questions could be skipped. They measured self-reported time to complete the training, its helpfulness, knowledge of the *Voluntary Assisted Dying Act 2017* (Vic) ("VAD Act"), and confidence in applying it, main reason for undertaking the training, willingness to participate in VAD and in what capacity, conscientious objection to VAD practice(s), change of opinion on willingness to provide VAD due to the training, and opinions on unclear or challenging parts of the VAD Act. Open-ended comments were sought on how training could be improved, what aspects should be retained in future iterations, and general feedback.

In addition, information on doctors' demographics and professional background (seven questions) was collected at the start of the training. Variables were gender, age, state, location (rural/town/city), work setting, specialist medical college (and specialty if a physician), and years since fellowship.

A third data source included post-program assessment data. This included doctors' score for each assessment attempt and the number of attempts to pass the assessment.

### Analysis

Quantitative data were managed and analyzed using SPSS 25 (IBM Corp., Armonk, NY, USA). Descriptive statistics (frequencies and percentages) were examined to explore the characteristics and distribution of all variables. We examined patterns of missing data (item and unit nonresponse) and potential presence of non-response bias. To examine whether respondents and nonrespondents differed on demographic, professional, assessment, and attitudinal variables, we used *t*-tests and cross-tabulations with Chi-squared and Fisher-Freeman-Halton exact tests. Statistical significance was set at  $P \leq 0.05$ .

We also looked at associations between perceived helpfulness of training and participants' confidence in knowing and applying the Act using the Fisher-Freeman-Halton exact test.

Excel (Microsoft Corporation, Redmond, WA, USA) was used to manage qualitative data, and verbatim survey responses were classified, coded, and grouped into themes using thematic analysis (Braun and Clarke, 2006).

### **Ethical considerations**

This research was approved by human research ethics committees at the Queensland University of Technology and the University of Queensland. Potential participants were provided with an information sheet explaining the research and inviting their participation and asked if they consented to their demographic and assessment data (already being collected in the training) to being further analyzed for research purposes. Only data provided by doctors who provided this consent are analyzed and reported here. For the post-training survey, participants provided informed consent to participate by submitting their completed survey.

### **Role of the funding source**

The Victorian Government funded the design and development of the mandatory training but did not fund this research. All training material was initially designed and drafted by the project team. The Victorian Government reviewed and commented on drafts of the training modules, assessment questions and the demographic and post-training surveys; set the assessment pass mark; and approved all final documents. It was not involved in the data collection or analysis but reviewed a draft manuscript.

## **Results**

### **Missing data analysis**

Eighty-one percent of the doctors who completed the training in the study period (233/289) completed the survey. Ninety-two percent of doctors (266/289) provided consent to analysis of demographic and assessment data for research purposes.

The characteristics of survey nonrespondents were like respondents with respect to gender, age, state, location, physician specialty, and total attempts to pass the assessment. The two groups differed with respect to work setting ( $P = 0.005$ , survey respondents were less likely to work in specialist rooms) and college ( $P = 0.006$ , survey respondents were less likely to be members of Australian College of Rural and Remote Medicine or Royal Australasian College of Surgeons and more likely to be members of Royal Australian College of General Practitioners).

Doctors who consented to their demographic and assessment data being analyzed for research purposes were representative of all doctors who completed the training in the study period with respect to demographic, professional, assessment, and attitudinal variables.

Missing data for survey questions was in the range of 0–4% for all but one question, participants' main reason for doing the training (52% missing data). The characteristics of item nonrespondents differed from respondents on several variables, suggesting that data were not missing at random. Hence, this variable was removed from the analysis. Doctors' demographic and assessment information did not contain any missing data.

### **Who has undertaken and passed this training?**

Table 1 provides demographic information for the 266 doctors who completed the training and assessment and consented to

their demographic and assessment data being used for research. Fifty-six percent of doctors were male, reflecting the medical profession (56% male) in Victoria (Medical Board of Australia, 2019). Most participants (82%) were aged between 36 and 65 years. Almost all doctors had a primary practice address in Victoria, and 72% were from cities with a population of 100,000 or more. Doctors primarily worked in general practice (52%) or hospital (35%) settings. General practitioners (47%) and medical oncologists (16%) were the most common specialties completing the training. Doctors were most often more than 10 years post fellowship (68%).

Sixty-five percent of doctors passed the training on their first attempt (19% passed at the second attempt, 10% at the third attempt, 5% at the fourth attempt, and 1% at the fifth and final attempts).

### **Attitudes toward participating in VAD**

To provide context for the below data, in Victoria, a "co-ordinating doctor" has overall patient responsibility from patient's first request to prescribing the VAD medication (and, in limited circumstances, administering the VAD medication). The "consulting doctor" is only responsible for undertaking the second eligibility assessment. If eligible, a patient will self-administer the VAD medication or, if unable to self-administer or digest the medication, practitioner administration is permitted.

Of the doctors who completed the post-training survey ( $n = 233$ ), most (80%) reported willingness to participate in VAD (2% unwilling and 18% unsure) (Table 2). Eighty-five percent of these willing doctors reported being willing to act as a co-ordinating medical practitioner for self-administering patients; this reduced to 44% for practitioner administration (2% reported being willing to act as a co-ordinating medical practitioner but did not provide further detail). Sixty percent were willing to be the consulting practitioner.

Most doctors (76%) did not have a conscientious objection to participating in any VAD practice (11% had a conscientious objection and 12% unsure). Among those with a conscientious objection ( $n = 26$ ), willingness to participate in VAD practices corresponded to the degree of involvement, with 4% objecting to providing information about VAD and 85% objecting to administering VAD medication.

### **Attitudes toward training**

The training most commonly took 6 h to complete (range 2 h to over 9 h). Almost all participants (97%) found the training helpful or very helpful. Following training, participants were generally confident (69%) or very confident (24%) in their knowledge of the Act (7% neutral). Participants were generally confident (66%) or very confident (22%) in their ability to apply the Act (11% neutral and 2% not confident). There was a significant positive association between perceived helpfulness of the training and participants' confidence in both knowing and applying the Act (both  $P < 0.001$ ). Twenty-three percent of participants reported that the training had changed their opinion on willingness to provide VAD in general or some aspect of it (none of these participants were unwilling to participate in VAD though 36% were unsure).

### **Qualitative data**

Common themes were that the training was high-quality, thorough and comprehensive. Many doctors reported that it was time-

**Table 1.** Characteristics of doctors who completed the training and assessment (*n* = 266)

Variable	<i>n</i>	%
<i>Gender</i>		
Male	150	56.4
Female	116	43.6
<i>Age (years)</i>		
35 or under	27	10.2
36–45	66	24.8
46–55	81	30.5
56–65	70	26.3
>65	22	8.3
<i>Location</i>		
City (100,000 + people)	191	71.8
City (50,000–99,999 people)	14	5.3
City (20,000–49,999 people)	12	4.5
Town (10,000–19,999 people)	16	6.0
Rural or town (<10,000 people)	33	12.4
<i>Setting</i>		
General practice	139	52.3
Hospital	92	34.6
Outpatient clinic	23	8.8
Community based	5	1.9
Other	7	2.7
<i>College</i>		
Royal Australian College of General Practitioners	124	46.6
Royal Australasian College of Physicians	92	34.6
Australian and New Zealand College of Anaesthetists	10	3.8
Australian College of Rural and Remote Medicine	12	4.5
Royal Australasian College of Surgeons	5	1.9
Royal Australasian College of Medical Administrators	3	1.1
Royal Australian and New Zealand College of Obstetricians and Gynaecologists	5	1.9
Royal Australian and New Zealand College of Radiologists	4	1.5
Royal Australian and New Zealand College of Psychiatrists	3	1.1
College of Intensive Care Medicine of Australia and New Zealand	1	0.4
Other	5	1.9
<i>Specialty (Royal Australasian College of Physicians fellows only)</i>		
Medical oncology	42	15.8
Neurology	11	4.1
Geriatric medicine	8	3.0
Respiratory medicine	4	1.5
Clinical haematology	7	2.6
Palliative medicine	6	2.3

(Continued)

**Table 1.** (Continued.)

Variable	<i>n</i>	%
General and acute care medicine	6	2.3
Cardiology	3	1.1
Infectious diseases	3	1.1
Nephrology	2	0.8
<i>Years since fellowship</i>		
<5	49	18.4
5–10	37	13.9
>10	180	67.1

consuming; this was seen as both positive (helpful and necessary) and negative (repetitive content and length as a potential barrier to undertaking training). Several doctors wanted more information on procedural and clinical aspects of VAD and suggested training include copies of required forms. Some doctors sought more information on the VAD medication including potential adverse reactions and their management. Assessment was perceived as difficult but necessary to ensure sufficient knowledge.

## Discussion

### *Availability and willingness of doctors needed to provide VAD*

VAD is a new medical practice in Victoria, and patient access to it requires willing and qualified doctors (Hanssen-de Wolf et al., 2008; Oliver et al., 2017; Rutherford et al., 2021). The legal requirement to undertake rigorous training is a safeguard in the Victorian system but it has implications for the availability of qualified doctors.

In Victoria's first 2 years of operation, 331 individuals received VAD (Voluntary Assisted Dying Review Board, 2021) requiring at least 662 eligibility assessments. Other individuals, beyond those 331 who received VAD, would also have been assessed: patients assessed as eligible but who died from their underlying illness or withdrew from the process; and patients who were assessed as ineligible. As of 30 June 2021, 289 doctors had passed the training, so were eligible to provide VAD. Data are not available on whether some patients could not access VAD due to a lack of qualified doctors. There is, however, anecdotal evidence that a few doctors have taken on a large number of VAD cases to meet demand. Further research on this issue is critical to ensure that the safeguard of mandatory training does not dissuade doctors from becoming VAD providers (Rutherford et al., 2021; Sellars et al., 2021).

An associated issue is doctors' willingness to be involved. Although doctors may be "qualified" to provide VAD, "willingness" to participate is a more realistic measure of doctor availability. Of the 233 doctors who completed the survey, 80% reported willingness to participate. Of this cohort, 85% were prepared to be a co-ordinating doctor for self-administration, but only 44% for practitioner administration. As of 30 June 2021, 185 trained doctors had been involved in one or more cases as either a co-ordinating or consulting medical practitioner (Voluntary Assisted Dying Review Board, 2021). The finding that willingness to participate in VAD practices corresponds to the degree of involvement (including a strong preference for self-



**Table 2.** Attitudes toward participating in voluntary assisted dying (VAD) among doctors who completed the training and assessment ( $n = 233$ )

Variable	No. of observations	Frequency	Valid %
<i>Willingness to participate in VAD</i>			
Yes	226	180	79.6
No	226	5	2.2
Unsure	226	41	18.1
<i>Willingness to perform VAD role<sup>a</sup></i>			
Co-ordinating medical practitioner (self-administration)	175	148	84.6
Co-ordinating medical practitioner (practitioner administration)	175	77	44.0
Co-ordinating medical practitioner (unspecified)	175	4	2.3
Consulting practitioner (eligibility assessment only)	179	105	58.7
<i>Conscientious objection to participating in VAD</i>			
No	228	174	76.3
Yes	228	26	11.4
Unsure	228	28	12.3
<i>Conscientious objection to participating in specific VAD practices<sup>b</sup></i>			
Providing information about VAD	25	1	3.8
Participating in the request and assessment process	25	4	15.4
Applying for a VAD permit	25	7	26.9
Prescribing VAD medication	25	7	26.9
Being present at the time of self-administration	25	10	38.5
Being present at the time of practitioner administration	25	14	53.8
Administering VAD medication	25	22	84.6

Note: Except where indicated, missing data is due to nonresponse.

<sup>a</sup>Question only answered by participants who reported willingness to perform a VAD role ( $n = 180$ ).

<sup>b</sup>Question only answered by participants with a conscientious objection to participating in VAD ( $n = 26$ ).

administration) has been reported elsewhere (Karapetis *et al.*, 2018; Yoong *et al.*, 2018). Furthermore, while our survey question on VAD participation was worded generally, willingness to provide VAD may be situation and/or patient-specific (Rutherford *et al.*, 2021).

These data on self-administration may not raise concerns in Victoria as self-administration is the default method (data from the first 2 years show 282 patients self-administered and only 49 received practitioner administration) (Voluntary Assisted Dying Review Board, 2021). However, having fewer doctors being prepared to administer the medication might raise issues

in other Australian States where greater patient choice means practitioner administration is more likely to be requested.

Over time, Australian doctors may become more comfortable with practitioner administration, and we note that self-administration as a default is uncommon internationally. While there are exceptions (e.g., the United States where only self-administration is available) (Downie *et al.*, 2021), practitioner administration is the norm internationally (e.g., in the Netherlands, Belgium, and Canada) (Emanuel *et al.*, 2016).

The characteristics of doctors undertaking the training also have implications for access. The profile of trained doctors reflects the broader maldistribution of Australia's medical workforce but appears to be further skewed toward urban general practitioners (National Rural Health Alliance, 2019; Medical Board of Australia, 2021). The high numbers of general practitioners may suggest doctors are willing to provide assistance to regular patients (Sercu *et al.*, 2012). This may also reflect general practitioners receiving more requests than other specialists (De Boer *et al.*, 2019).

The significant proportion of doctors from larger cities also suggests (unsurprisingly) that access may be more challenging for patients in regional or rural Victoria. This potentially highlights the importance of general practitioner engagement for individuals living in rural Victoria. Furthermore, having only a small pool of participating doctors apart from general practitioners or medical oncologists (Voluntary Assisted Dying Review Board, 2021) may impact access for patients with a nonmalignant diagnosis. Furthermore, Victorian law was interpreted to require one eligibility assessment by a doctor who was a specialist in the patient's illness (White *et al.*, 2020). While there may be changes in the expertise and experience required for this purpose, there must be sufficient willing and qualified specialists who are geographically accessible to patients.

Patient access issues can, in turn, affect the welfare of doctors, particularly in locations or speciality fields where relatively few doctors have completed the training. The risk is that the VAD workload falls on a small cohort of doctors, placing them in danger of burnout, particularly if this new medical practice does not have the support of their colleagues or professional colleges and societies (Khoshnood *et al.*, 2018). There is evidence, however, of growth in the numbers of Victorian doctors undertaking the training and providing VAD (Voluntary Assisted Dying Review Board, 2021) and that is anticipated to continue.

### *Is the training an effective safeguard?*

Mandatory training was recommended to ensure consistent and high-quality decision-making by doctors under the VAD Act (White *et al.*, 2021). While it is not possible to measure in practice whether this *specific* safeguard is making the VAD system safer, some data reported here provide supporting evidence that this policy goal is likely being met.

Firstly, doctors' experience suggests deep engagement with the training, in terms of length of time to complete it and difficulty of the assessment (90% pass mark). Doctors reported finding the assessment difficult, consistent with only 65% passing on the first attempt.

Secondly, after doctors undertook the training, many were highly confident in their knowledge of the Act, and their ability to apply it in practice, suggesting that doctors possessed the required knowledge to appropriately interpret the legal framework.

It is relevant that doctors in another study about end-of-life law were found to be generally accurate in their self-assessment of legal knowledge (White et al., 2014).

Finally, and while not constituting direct evidence of legal knowledge, many doctors reported positive experiences with the training, finding it helpful, high-quality, thorough and comprehensive. Positive training experiences are likely to reflect deep engagement (Kucuk and Richardson, 2019).

### Strengths and limitations

This study presents data from the world's first legislatively-mandated VAD training. It provides novel information on the role of such training in preparing doctors to provide VAD consistent with a new and complex legal framework. It also provides evidence regarding doctors' nuanced attitudes toward participating in VAD and conscientious objection to specific VAD practices.

This study also has several limitations. As an observational cross-sectional study, results are a snapshot during the study period. It is not possible to isolate the training's effect on outcomes such as participants' confidence in knowledge of the Act or their ability to apply it. Although training and assessment data were available for 92% of the doctors and the post-training survey response rate was 81%, the sample size was relatively small, and we cannot exclude some degree of nonresponse bias. This may reduce the extent to which participants' attitudes toward participating in VAD and views on their experience can be generalized to the population of all training participants.

### Suggestions for further research

Doctors' views of the training have been described in studies on the early operation of Victorian VAD laws (e.g., Rutherford et al., 2021; Willmott et al., 2021). Further targeted research is needed to understand the impact of mandatory training on doctors' interpretation of the legal framework and decision-making in VAD practice. In addition to information on the availability of doctors providing VAD (reported by the Voluntary Assisted Dying Review Board), further research should also determine how to best achieve the safeguarding function of training while ensuring it does not adversely affect patient access to VAD or doctor welfare.

### Conclusion

Mandatory training before doctors can be involved in providing VAD is a key safeguard in Victoria's VAD system. It aims to ensure those involved have a minimum level of legal knowledge. Although unique at the time, this legislatively-mandated training has become an established part of the Australian VAD model and is likely to be considered by other jurisdictions contemplating reform. Early Victorian data suggest a mandatory state-led training program can support doctors in undertaking their roles, with participants reporting high levels of confidence in knowing the VAD Act and being able to apply it in practice.

**Data availability statement.** To protect participants' privacy, participant data are not available. However, additional information regarding the findings presented can be requested from the corresponding author.

**Author contributions.** All principal researchers (LW, BW, PY, and MP) were involved in conceptualization of this research. LW, BW, RF, and KW were involved in analysis and interpretation. LW, BW, and RF drafted the paper with input from PY, MP, and KW. All authors contributed to critical

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**Conflict of interest.** LW, BW, PY, and MP were engaged by the Victorian Government to design and provide the legislatively-mandated training for doctors involved in voluntary assisted dying described in this article. KW is employed on the project.

**Ethics approval.** Approval was obtained from the human research ethics committees at the Queensland University of Technology (approved 5 March 2019 – approval number: 1900000136) and The University of Queensland (approved 5 March 2019 – clearance number: 2019000467).

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**Models of care for voluntary assisted dying: A qualitative study of  
Queensland's approach in its first year of operation**

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## **Abstract**

**Objective:** Voluntary assisted dying (VAD) began in Queensland in January 2023 but little is known about its practical operation. This research examined models of care for providing VAD in Queensland.

**Methods:** Semi-structured interviews were conducted with 24 participants involved with VAD delivery across Queensland's 16 Health and Hospital Services (HHSs). Participants included HHS VAD Coordinators, nurse practitioners and nurses who acted as administering practitioners, and Queensland VAD Support and Pharmacy Service (QVAD SPS) staff.

**Results:** Five themes about Queensland VAD models of care were developed: VAD is accessed almost exclusively through the public sector via HHSs, influenced by a Health Service Directive; local models of care vary; nurses play significant roles facilitating access to and providing VAD; QVAD SPS has been instrumental supporting HHSs and ensuring statewide access as back-up VAD provider; and VAD services need more resourcing.

**Conclusions:** The Queensland approach to providing VAD has been largely successful in ensuring patient access across the state. But it differs from previous Australian VAD models with access predominantly through the public sector, greater roles played by nurse practitioners/nurses, and VAD being provided by QVAD SPS. Under-resourcing and consistency in provision of VAD services remain challenges.

## Introduction

All Australian states and the ACT have voluntary assisted dying (VAD) laws. The Northern Territory is actively considering reform.<sup>1</sup> There is a broad 'Australian model' with narrow eligibility criteria and many procedural safeguards (Box 1).<sup>2</sup> However, states have implemented VAD laws differently.

In Queensland, where VAD has been available since January 2023, Queensland Health issued a Health Service Directive (HSD) requiring each of its 16 Health and Hospital Services (HHSs) to provide a VAD service (Box 2).<sup>3</sup> Each HHS was required to establish 'a model of care to provide timely, publicly funded voluntary assisted dying services for eligible people' including 'all steps of the voluntary assisted dying process'. The HSD did not prescribe a model of care nor its implementation. HHSs did not receive dedicated funding for providing VAD.<sup>4</sup>

Another key implementation feature is the Queensland VAD Support and Pharmacy Service (QVAD SPS).<sup>4</sup> It differs from other states in that it:

- Combines in a single service:
  - a care coordinator service established under the Act 'to provide support, assistance and information to people'<sup>5</sup> – *QVAD Support*;<sup>6</sup> and
  - a statewide pharmacy service to supply VAD medication – *QVAD Pharmacy*.<sup>7</sup>
- Has interdisciplinary staff with nursing and social work care coordinators, pharmacists and a psychologist, led by a palliative care physician.
- Includes practitioners, primarily nurses, authorised to provide VAD as part of QVAD Support (Queensland law permits doctors, nurse practitioners and nurses to be 'administering practitioners').

This is the first empirical study of Queensland's VAD system, examining models of care for providing VAD using qualitative interviews with HHS VAD coordinators, nurses providing VAD and QVAD SPS staff.

## **Methods**

### Recruitment

Recruitment used purposive sampling across two phases. Phase one (part of a wider study) recruited nurses who provided VAD as 'administering practitioners'. QVAD SPS forwarded study details to all eligible nurses. Most of these nurses were also a VAD Coordinator in their HHS or worked for QVAD SPS. Phase two sought VAD Coordinators from remaining HHSs (whether or not a nurse who had provided VAD) and the wider QVAD SPS team for statewide insights. Phase two participants were recruited at a clinical symposium and via direct email to remaining HHS VAD Coordinator email addresses. Snowball recruitment was used throughout. Recruitment ceased on data saturation (information redundancy).<sup>8</sup>

### Data collection

Twenty-four semi-structured interviews occurred between October 2023 and March 2024 by BPW, AW and LW (with one a designated lead). BPW attended all, AW all except one and LW four interviews. All but one were Zoom video conferences (one via telephone) and lasted between 34 and 92 minutes. Interviews were audio-recorded and transcribed verbatim. Participants could amend their transcript (member checking),<sup>9</sup> and some provided supplementary information (e.g. VAD death numbers).

Our interview guide (Supplementary Material) was based on analysis of the Queensland VAD system,<sup>2, 10</sup> similar research from other jurisdictions<sup>11-14</sup> and research team discussions. Open-ended questions explored system operation, with novel features of Queensland's implementation specifically explored.

### Analysis

NVivo 14 (QSR International) was used to store and code transcripts and supplementary information. Thematic analysis was applied using codes developed deductively (based on

previous research and field knowledge, e.g. role of VAD coordinators and impact of resourcing, and iterative discussion of early themes) and inductively.<sup>15</sup> Interviews were coded by AW using a framework developed with BPW and LW and periodically refined. BPW and AW undertook iterative analysis during data collection including discussions and/or shared journaling about key implications after each interview and periodic review of data as a whole (e.g. after the first nine interviews). Themes developed were discussed and tested by all authors.

### Ethics approval

Study approval was by Queensland University of Technology Human Research Ethics Committee (2000000270). Participants provided informed consent.

### **Results**

Twenty-four participants were interviewed with representation from 15 of the 16 HHSs (Table 1). Interviewees were primarily nurses (19) with two doctors and three other health professionals. Five themes were developed about Queensland VAD models of care.

### VAD is accessed almost exclusively through the public sector via HHSs, influenced by the HSD

Participants described the vast majority of VAD being accessed through the public sector, including rural GPs working within a HHS or specifically employed by it for VAD work. A QVAD SPS participant, drawing on the fact that its service issues all VAD medication in Queensland, put the figure at 'about 90%'.

Participants identified the HSD's influence because it mandated a local model of care for public access to VAD in each HHS. Participants perceived the HSD positively because it required at least some engagement in all HHSs.



*I think the directive was good. I think it was great. I think that that really socialised VAD. We had to have a policy in place. We had to have a guideline in place to really set up those systems of governance.*

#### Local models of care vary

An outcome of the HSD not prescribing how a model of care should be implemented is 'huge variety' in models.

*However it [the HSD] wasn't prescriptive in any way. And some HHSs embraced this better than others. Some HHSs provided funding for dedicated authorised medical practitioners and authorised nurses as well as administrative staff. And other HHSs did not provide that support.*

All HHSs had a VAD Coordinator who served as a contact point. This was generally a nurse, with some allied health such as social workers. But the nature of these roles varied. Some Coordinators had a navigating role supporting patients, families and health professionals while others played only an arms-length facilitative role (e.g. just connecting patient with doctors).

VAD workforce within HHSs also varied. Some Coordinators were designated appointments with allocated VAD workloads. Some HHSs also had a team supporting VAD that may include medical, nursing or administrative appointees (and occasionally all). However, some HHSs did not have a dedicated workforce, and VAD Coordinators performed their role without workload recognition and on top of existing job/s.

*They simply said, 'Just add this [VAD Coordinator] to your job as [current position].'*

*So what happened was in some of these smaller – and in larger ones as well – that people who were already fully employed were also given the title of, 'You're the VAD service provider as well.'*

*So we have no funding. ... We've got no admin. We've got nothing. We just do it.*

Participants reported variation in governance and oversight. Some described clear reporting lines and strong support from HHS management. Others described a lack of clarity about reporting – ‘no-one knows what I do’ – and unsupportive or disinterested HHS leadership.

Nurses play significant roles in facilitating access to VAD and providing it

Nurse practitioners and nurses play a significant role in VAD in Queensland. HHSs generally opted for a nurse-led response (most VAD Coordinators are nurses), with one participant observing this was a cost-effective path to HSD compliance.

Nurses, generally as VAD Coordinators, often led the establishment of HHS VAD processes. They often facilitated VAD applications to reduce administrative and logistical burdens on doctors, freeing them to undertake exclusively medical roles like eligibility assessments.

Appointing nurses as Coordinators or within HHS VAD teams resulted in nurses acting as administering practitioners. Fifteen of 19 nurses interviewed had undertaken practitioner administration. Some nurse participants described accompanying patients through the VAD process and at all appointments (including eligibility assessments), culminating in them being the administering practitioner.

For some participants, practitioner administration was a core role, with a few providing this more than 20 times. In some HHSs where practitioner administration is common, some reported this role being primarily undertaken by nurses.

*I see everybody that comes through, all the referrals come through. I go and visit them at home or in a ward ... [W]herever they are, I'll go and see them and talk them through the whole process from the beginning. Make that initial introduction because I'll be the one that supports them through the process. ... We have a different model here in VAD. We agreed way at the beginning with the SMOs [senior medical officers] that it made sense for me to do the things that I can do. And for them to spend time doing the things that they can do that I can't do. So that's why I ended up having so many administrations. It makes sense for me to do the administering. It's*

*better to use your time to do the coordinating and the consulting and the final requests that I can't do.*

QVAD SPS has an integral role in supporting HHSs and as back-up VAD providers to ensure statewide access

QVAD SPS is an integral part of Queensland's approach to VAD. Participants were glowing about its work, including support provided to HHSs and VAD Coordinators, and patients and families through QVAD Support.

*This [HHS] service wouldn't have survived without QVAD Support.*

Some particularly valued that QVAD SPS was interdisciplinary with care coordinators and pharmacists in the same team.

Although assisting all HHSs, much QVAD Support work focused on 'gap-filling' where VAD was not available locally. Participants also spoke about QVAD SPS's efforts to build this capacity in these regions.

*Probably the first three months of the year, we didn't have anyone here, we had no authorised doctors...so it was basically just QVAD Access that we were using, so they were flying doctors up, and almost every week. We were really busy right from the beginning, there was no lead in period, it was just right from the start.*

This gap-filling role included QVAD SPS staff acting as administering practitioners. Administration was not an intended QVAD Support function but this was needed in HHSs without local capacity, or in complex cases where additional experience was beneficial. This role was often fulfilled by QVAD SPS nurses (linked with above theme), and was sometimes acknowledged as challenging given limited time to establish patient relationships.

*It's been gap-filling for want of a better term when a patient's priority has been that they've needed it, and nobody else has been able to go and do it. They reach out to us and then we'll, one of us is asked, obviously, no one's forced into doing anything,*

*if we would like to go and do an administration. And then we travel and do the administration.*

#### More resourcing is needed within HHSs

Many participants were concerned VAD was under-resourced in their HHS. Some described HHSs 'ticking the box of the HSD' so it had VAD in theory, but the practice was quite different.

*There's absolutely no money here for us ... no one wants to pay for it. ... It's law, it's legislation, you have to provide the service. So find some money and get on with it, basically.*

There were also reports that Coordinators and other clinical VAD roles had insufficient time for the work volume, particularly given higher than expected demand. Participants in HHSs with dedicated medical VAD roles (compared with nurse-only models) appreciated this structural access to doctors, who are needed for VAD eligibility assessments, as this facilitated timely progress for patients through the VAD approval process. A few HHSs with large VAD workloads valued administrative support given the paperwork and time intensive nature of assessment processes.

Linked with under-resourcing was the temporary nature of VAD appointments. Many participants reported job insecurity made them vulnerable and risked VAD service continuity. However, some described recent improvements in resourcing within their HHS including making roles permanent and allocated VAD time within workload.

*I am just hellishly lucky that our health service realised that they would need to make permanent positions and have done so. Albeit a bit slightly slower than we hoped. But all the other health services, they're still working on temporary contracts and things because nobody's got any money and nobody wants to give any money from any other service to run this service. So I think that was a real miss that there should*

*have been some way of ongoing funding for this. You can't really demand that health service runs a service but then just say, 'But we're not going to give you any financial assistance to do so.' But then you can't not run a service because then we're breaking an HSD.*

These factors led to some participants feeling burnt out and overloaded, commonly compounded by the isolation of being a 'lone practitioner'. Many reported no alternative support in their HHS: 'I haven't [been able to] have a holiday'. However, many described feeling supported by QVAD SPS with the VAD process and personally (including through its community of practice). Another protective factor was the rewarding nature of supporting patients to have their choice of VAD.

## **Discussion**

VAD access in Queensland has been shaped by implementation, especially the HSD and QVAD SPS. Significantly, the vast majority of VAD (~ 90%) is accessed through the public sector. This appears to be different from other states. While available data is not definitive, GP VAD participation can be a useful proxy given GPs primarily work in the private sector. Data in VAD Review Board reports varies (e.g. *registered* for VAD training versus *participating* in VAD) but GPs account for 81% of practitioners in Tasmania,<sup>16</sup> 60% in South Australia,<sup>17</sup> 59% in Victoria,<sup>18</sup> and 45% in WA,<sup>19</sup> suggesting VAD access is spread across public and private sectors elsewhere. Also noteworthy is Queensland's statewide VAD availability. Queensland has VAD practitioners in each HHS area<sup>4</sup> while Victoria and WA report areas without them.<sup>18,19</sup>

Both features of access in Queensland – public sector access and statewide availability – were reportedly driven by the HSD mandating each HHS have a local model of VAD care. The HSD is a stronger policy response than adopted in previous states with VAD. For example, Victoria's 'VAD model of care pathways for health services' allowed services, including public health services, to choose their level of involvement in VAD.<sup>20</sup> The least

involved pathway was to provide only 'information and support',<sup>20-23</sup> the pathway chosen by most organisations in the first two years of operation.<sup>24</sup> The resulting inequities in patient access to VAD due to variations in approaches by institutions is problematic.<sup>25</sup>

The role of nurse practitioners and nurses in Queensland is also striking. For example, 15 of our sample had provided practitioner administration, consistent with Queensland Board data that 14 nurse practitioners and nurses had undertaken this role in the first six months.<sup>4</sup> By contrast, the only report of nursing engagement as administering practitioners (permitted in WA, Tasmania and NSW) is in WA with one nurse practitioner providing practitioner administration over the last two years.<sup>19</sup>

Again, the HSD likely leads to greater nursing participation, particularly as administering practitioners. HSD obligations were usually met by HHSs through nursing appointments, generally as VAD Coordinators. This greater nursing involvement with patients through accompanying them in the VAD process may remove the known barrier to undertaking practitioner administration of not having a prior patient relationship.<sup>19</sup> The 'gap-filling' role of QVAD Support has also contributed to greater nursing participation in VAD as its nursing staff acted as administering practitioners when needed, although generally without the same opportunity to establish patient relationships.

The QVAD Support service has also had wider and significant impact on access, particularly in ensuring statewide availability. Its ability to provide assessments and/or administration to meet unmet demand in HHSs has been pivotal. Although not an anticipated function of QVAD Support, this was needed to ensure statewide access despite the HSD and other initiatives like the QVAD Access travel scheme (similar to other states).

This research also identified challenges for Queensland's VAD implementation. A key issue is resourcing, particularly in HHSs where the model of care was reportedly tokenistic. Limited guidance in the HSD about the content of models of care led to significant variation. Greater

direction about minimum requirements for a local VAD service may be beneficial, informed by research about optimal models of care.

Further, a larger VAD workforce is needed, even in HHSs with well-established VAD services, to meet 'significant'<sup>4</sup> demand and for workforce sustainability, a recognised issue nationally.<sup>4,13,19,26-27</sup> Initiatives in some HHSs of increased medical appointments and making VAD roles permanent are important to consider. Resourcing and sustainability are also important for QVAD SPS as their practitioner administration roles are time and resource intensive. Additional HHS VAD capability may assist with reducing this load, as may QVAD SPS's efforts to build local capacity.

Resourcing also includes seeking opportunities for greater private sector participation, particularly through primary care. While reliable public sector access should be preserved to ensure equity, access is enhanced when VAD is available in a range of settings. GPs are the first port of call for many patients,<sup>12</sup> but a key barrier is the lack of remuneration, particularly from Medicare.<sup>26</sup> More research on the lack of VAD provision outside the public sector in Queensland is needed.

### Limitations

A study strength is recruitment reach with participants from 15 of 16 Queensland's HHSs, as well as a considerable number of QVAD SPS staff. However, participants were all employees of Queensland Health and so had limited insight into VAD in the private sector (albeit a very small component of VAD in Queensland). Another strength is that this is the first reported study of Queensland VAD practice. However, the VAD system's first year of operation represents a point in time and (as participants noted) the system is evolving. Finally, most participants were nurses and perspectives of other key participants, particularly doctors, are needed.<sup>28</sup>

### **Conclusion**

Despite Australian states having similar VAD laws,<sup>2</sup> implementation has a significant impact on VAD practice. Key differences in Queensland's VAD system stem from its HSD mandating all HHSs to have a model of care for public access to VAD and its distinctive QVAD SPS. This has led to enhanced statewide access to VAD and through the public sector, and an increased role in VAD for nurse practitioners and nurses. However, resourcing and consistency in VAD provision remain challenging. More research is needed as to what constitutes an optimal model of care for VAD services.



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<b>Table 1: Characteristics of interviewees (n=24)*</b>	
<b>Characteristic</b>	<b>Number of participants</b>
<b>Age (years)</b>	
31-39	7
40-49	5
50-55	11
56-75	1
<b>Gender</b>	
Female	22
Male	2
<b>Profession</b>	
Nurse practitioner /nurse	19
Social work/allied health	3
Doctor	2
<b>Location of primary practice</b>	
Metropolitan	12
Regional	7
Rural/remote	5
<b>Work setting</b>	
HHS VAD Coordinator	14
QVAD SPS	5
Other roles#	5
<p>* One interview was conducted with an additional participant but no system perspective was obtained so that participant is not included in this study.</p> <p># Other roles were: members of HHS VAD teams actively involved in providing VAD (but not a VAD Coordinator), and one nurse participant who was not part of a VAD team but had a relevant clinical leadership role in their HHS which led to VAD provision.</p>	

## **Box 1: Brief overview of Australian VAD laws\***

### **Eligibility criteria**

- A person must be an adult, have decision-making capacity, be seeking VAD voluntarily and without coercion, meet residency requirements, have a qualifying disease, illness or medical condition, and be experiencing suffering.
- The medical condition must be advanced and progressive, and one that will cause death, in most jurisdictions, within 6 months or 12 months for neurodegenerative conditions. (Queensland has a global 12-month timeframe; the ACT does not have a timeframe refers to people 'approaching the end of their life'.)

### **Request and assessment process**

- A person must make three separate requests for VAD.
- Eligibility criteria must be assessed by at least two independent medical practitioners (one can be a nurse practitioner in the ACT).

### **Other example safeguards**

- Restrictions on how VAD may be raised with patients, including Victoria and South Australia prohibiting registered health practitioners from initiating a discussion about VAD.
- Mandatory training for health practitioners involved in assessing and providing VAD along with required minimum qualifications/experience.
- Oversight Boards which review individual cases of VAD and report publicly on collected aggregate data.
- Four states require prospective approval of VAD from a Board or government official.

\* Because of differences in Australian VAD laws, this Box provides only a general overview and does not address some local variations.<sup>2</sup>

## **Box 2: Extracts from Health Service Directive ‘Access to voluntary assisted dying’<sup>3</sup>**

### **Purpose**

This directive outlines the mandatory requirements for Queensland Health Hospital and Health Services to safely and effectively:

- manage and respond to requests for information about and access to voluntary assisted dying, and
- deliver voluntary assisted dying services.

....

### **Outcomes**

Hospital and Health Services will achieve the following outcomes:

- Each Hospital and Health Service establishes a model of care to provide timely, publicly funded voluntary assisted dying services for eligible people.
- People who request information about voluntary assisted dying receive appropriate information and support from the Hospital and Health Service.
- Eligible people who request access to voluntary assisted dying are supported through the process by the Hospital and Health Service and receive safe, high quality, person-centred care.
- Hospital and Health Service employees are informed, educated, competent, and aware of their rights, responsibilities, and local policies and procedures in order to meet their legislative obligations.

....

### **Access requirements**

Hospital and Health Services must establish a model of care to provide timely, publicly funded voluntary assisted dying services for eligible people. This includes services required

to enable a person to complete all steps of the voluntary assisted dying process, from first request to administration of the voluntary assisted dying substance. It is not a requirement that voluntary assisted dying services are provided at every Hospital and Health Service facility, however, consideration should be given to a person's preferences around location of service delivery and place of death. These services must be delivered under the governance of the Hospital and Health Service.

...



## **Ethics approval**

Research ethics approval was provided by the Queensland University of Technology Human Research Ethics Committee (2000000270). All participants provided informed consent before participation in this research.

## **Data availability**

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions. The interview guide is available in Supporting Information File.

## **Conflicts of interest**

Ben P White and Lindy Willmott have received funding to conduct research on VAD from the Australian Research Council, state governments (including the Queensland Government) and philanthropic organisations. They were also engaged by three Australian state governments (Victoria, Western Australia, and Queensland) to develop the legislatively mandated training for health practitioners providing VAD in those states. Lindy is a member of the Queensland Voluntary Assisted Dying Review Board, the oversight body in Queensland. Rachel Feeney was engaged as a clinical consultant for the VAD Training Education Module for Healthcare Workers in Queensland. Laura Ley Greaves was employed by a Queensland HHS for the purpose implementing VAD and has also been engaged in VAD training projects.

## **Declaration of funding**

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# Access to voluntary assisted dying in Australia requires fair remuneration for medical practitioners

Medical practitioners are poorly compensated for their time and services in supporting patients through the voluntary assisted dying process

In six Australian states, voluntary assisted dying (VAD) is (or will be) a lawful end-of-life option for terminally ill competent adults. At the time of writing, VAD laws have commenced in Victoria (June 2019), Western Australia (July 2021) and Tasmania (October 2022), with 604 people completing the process in Victoria<sup>1</sup> and 171 people in Western Australia.<sup>2</sup> VAD laws have been passed and are set to commence in Queensland (1 January 2023), South Australia (31 January 2023) and New South Wales (28 November 2023).

VAD in Australia is tightly regulated. A person is only permitted to access VAD if they are deemed eligible by two medical practitioners (coordinating and consulting practitioner), both of whom need to possess certain qualifications and to have completed legislatively mandated training. Owing to the rigorous nature of the process, the time commitment by medical practitioners who support patients through the VAD process is considerable. This is particularly so for the coordinating practitioner who assumes primary responsibility for the patient during the VAD process, which based on ST's experience, typically requires 6–8 hours of commitment, all of which will be unremunerated (unless privately billed).

The obligations of a coordinating practitioner will (or are likely to) include:

- undertaking the mandatory training to assess patient eligibility (which typically takes 6 hours, but can take up to 9 hours);<sup>3</sup>
- travelling to patients (commonly the case as patients are often too ill to leave their homes);
- obtaining prognostic information from other practitioners to support an eligibility assessment;
- completing and uploading the required documentation to the online VAD portal; and
- providing support and information to patients, and their loved ones, throughout the process (and sometimes providing support during the bereavement phase).

## Payment structure for voluntary assisted dying services

Medical practitioners perceive that their VAD work is largely unremunerated, despite the significant time commitment involved.<sup>4,5</sup> Currently, there is no dedicated Medicare Benefits Schedule (MBS) item for VAD. The MBS general explanatory notes (GN.13.33) state that “euthanasia and any service directly related to the procedure” will not attract Medicare benefits but note

that “services rendered for counselling/assessment about euthanasia will attract benefits”.<sup>6</sup> No guidance is given by Medicare about what such services may be and which MBS items may be available for medical practitioners to claim in relation to them. As a result, individual medical practitioners must use their discretion to claim the appropriate MBS item(s), if any, based on the clinical circumstances of the services rendered.


Despite this apparent lack of engagement by Medicare on relevant MBS items, some guidance was offered in the Western Australian VAD parliamentary debates.<sup>7</sup> There it was suggested that MBS items could be claimed in relation to the VAD process despite no dedicated MBS item number being available.<sup>7</sup> It was observed, however, that no MBS item could be claimed for the administration of the VAD substance.<sup>7</sup> The inability to claim for administration is particularly significant in WA, with early data suggesting a much higher proportion of practitioner administration in WA compared with Victoria.<sup>8</sup>

Ultimately, the applicable MBS item number will depend on the duration, location and time of the consultation, and the nature of the disease. For VAD consultations occurring outside the clinical setting (eg, the patient's home), general practitioners may be able to claim MBS items related to general professional attendances (eg, items 24, 37, 47). Other MBS items relating to professional attendances may also be open to GPs in different settings and contexts (eg, private consulting rooms, residential aged care settings, out-of-hours consultations). Moreover, if a practitioner has an established relationship with the patient (which is not always the case in the VAD context), a claim may be made for a telehealth consultation (eg, items 91800, 91801, 91802).<sup>9</sup> However, caution is needed to ensure a telehealth consultation does not breach the Commonwealth Criminal Code.<sup>10</sup>

Fewer options are available for home visits made by other specialist medical practitioners, as the usual MBS items (eg, items 110, 116, 104, 105) only apply in consulting rooms and hospitals. While there may be scope for medical practitioners employed by a health service to provide VAD within the practitioner's existing clinical role,<sup>5</sup> given the labour-intensive nature of VAD work, some of this may need to occur outside work hours and will therefore be unremunerated. For completeness, we note that, depending on the clinical context and nature of the consultation, MBS items relevant to advance care planning generally<sup>11</sup> may also be available.

Outside the Medicare framework, state-based resources may compensate medical practitioners

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who provide VAD services. In WA, where there is no available local practitioner, a practitioner supporting patients in regional and remote regions may be compensated for their travel expenses and time through the Regional Access Support Scheme.<sup>12</sup> Further, to incentivise the uptake of VAD work in regional and remote areas where there are no VAD providers, the Regional Access Support Scheme funds have, on occasion, been used to remunerate medical practitioners for completing the mandatory training. Funding has also been made available in Victoria<sup>13</sup> to help patients cover the gap for medical practitioners that privately bill and, on occasion, compensate medical practitioners for regional travel. However, such funds are limited and capped per patient.

While it is open for doctors to privately bill their patients for this service,<sup>4,5</sup> medical practitioners have indicated reluctance to do so, expressing the view that this would be insensitive.<sup>5</sup> This is not a universal view, however, as there is evidence of some medical practitioners privately billing their patients,<sup>5</sup> a practice that is likely to become increasingly common as the number of patients seeking VAD grows.

### Provision of voluntary assisted dying services should be appropriately remunerated

VAD is a lawful medical service potentially available to a small number of eligible people at the end of life. Its sustainability depends on the availability of trained medical practitioners who are willing to provide that service. Despite suggestions by some that VAD would be provided by health practitioners seeking to profit,<sup>14</sup> early experiences suggest that the provision of VAD will not be financially rewarding. Indeed, the medical workforce is currently receiving limited compensation for their involvement in the process, unless they decide to privately bill. While there is some compensation for regional and remote provision, and some medical practitioners may be able to complete aspects of VAD provision within their ordinary clinical role, this does not cover the full gamut of VAD providers. Indeed, the ability to receive compensation is limited, particularly in cases where a medical practitioner must provide VAD services in a facility they are not employed by, or in the general practice context where there is a reliance on bulkbilling and fee-for-service remuneration. Similarly, many GPs, and other specialists, are operators of small businesses with overheads. It is unreasonable to expect such practitioners to provide services that cause their business and livelihood to suffer.

Early research suggests that some doctors are willing to provide VAD despite the lack of compensation because they feel it is the “right thing to do”.<sup>5</sup> Moreover, some are willing to provide outside normal clinical hours.<sup>5</sup> However, VAD providers have expressed concern that the recurrent underpayment may disincentivise them and others from doing this work in the future, because of the demanding workload and difficulties balancing VAD provision with existing clinical roles.<sup>4,5</sup>

Other funding models operate more fairly. In New Zealand, the Ministry of Health introduced an

assisted dying service funding model. Under the model, eligible practitioners can claim fixed payments for five modules: application and first opinion of eligibility; independent assessment of eligibility; competency assessment; decision about eligibility (and follow-up); and prescribing and administering the medication.<sup>15</sup> Further payments may be available for additional activities such as obtaining clinical notes, travel allowance, complex cases, and supporting practitioners.<sup>15</sup>

The reluctance of the federal government to provide adequate support for VAD provision, as evidenced by its position to exclude euthanasia from the MBS,<sup>6</sup> is hard to justify given that VAD laws have been enacted in six Australian states. Given the wide community support for VAD, it is reasonable to expect that there would be support for mainstream funding of VAD through Medicare. As each regime is broadly similar, MBS item numbers relevant to the service could be nationally applied.

Because of the limited remuneration available, the provision of VAD services largely relies on the goodwill of medical practitioners to undertake unpaid work. Inadequate remuneration, in addition to being unfair and unethical, is likely to impact the sustainability of the already stretched VAD workforce and hence the ability of patients to access VAD in the future. If the lack of public funding for VAD services results in more medical practitioners privately billing their patients, VAD will be less accessible to a subset of the population.

We support calls for uniform and transparent funding arrangements that ensure medical practitioners are fairly compensated for the medical services they provide,<sup>4</sup> and anticipate the new federal government may be more supportive of such reform. Failure to reform the current funding model is likely to result in an unsustainable medical workforce and an increasing reliance on private billing, which will adversely impact patients’ access to this lawful end-of-life option.

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