‘This is uncharted water for all of us’: challenges anticipated by hospital clinicians when voluntary assisted dying becomes legal in Victoria

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Abstract

Objective. The aim of this study was to identify the challenges anticipated by clinical staff in two Melbourne health services in relation to the legalisation of voluntary assisted dying in Victoria, Australia.

Methods. A qualitative approach was used to investigate perceived challenges for clinicians. Data were collected after the law had passed but before the start date for voluntary assisted dying in Victoria. This work is part of a larger mixed-methods anonymous online survey about Victorian clinicians’ views on voluntary assisted dying. Five open-ended questions were included in order to gather text data from a large number of clinicians in diverse roles. Participants included medical, nursing and allied health staff from two services, one a metropolitan tertiary referral health service (Service 1) and the other a major metropolitan health service (Service 2). The data were analysed thematically using qualitative description.

Results. In all, 1086 staff provided responses to one or more qualitative questions: 774 from Service 1 and 312 from Service 2. Clinicians anticipated a range of challenges, which included burdens for staff, such as emotional toll, workload and increased conflict with colleagues, patients and families. Challenges regarding organisational culture, the logistics of
delivering voluntary assisted dying under the specific Victorian law and how voluntary assisted dying would fit within the hospital’s overall work were also raised.

**Conclusions.** The legalisation of voluntary assisted dying is anticipated to create a range of challenges for all types of clinicians in the hospital setting. Clinicians identified challenges both at the individual and system levels.

**What is known about the topic?** Voluntary assisted dying became legal in Victoria on 19 June 2019 under the *Voluntary Assisted Dying Act 2017*. However there has been little Victorian data to inform implementation.

**What does this paper add?** Victorian hospital clinicians anticipate challenges at the individual and system levels, and across all clinical disciplines. These challenges include increased conflict, emotional burden and workload. Clinicians report concerns about organisational culture, the logistics of delivering voluntary assisted dying under the specific Victorian law and effects on hospitals’ overall work.

**What are the implications for practitioners?** Careful attention to the breadth of staff affected, alongside appropriate resourcing, will be needed to support clinicians in the context of this legislative change.

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**Introduction**

There is significant debate internationally about voluntary assisted dying (VAD), particularly in relation to existing values in end-of-life care. Evidence from other jurisdictions indicates that legalising VAD creates challenges throughout hospitals, not limited to specific departments or senior medical staff. The legalisation of VAD in Victoria, Australia, under the *Voluntary Assisted Dying Act 2017*, has implications for all specialties, and across multidisciplinary teams.

On 19 June 2019, voluntary assisted dying became legal in Victoria, and law reform is predicted to occur elsewhere in Australia. The Victorian approach to VAD is unique internationally (see Box 1). Terminally ill patients who meet the legislated criteria are able to request a prescription for a lethal oral medication to be self-administered or, in limited circumstances, a lethal injection. Coordinating medical practitioners apply to the Secretary of the Department of Health and Human Services for a VAD permit for the patient. The Act imposes various requirements on the medical practitioners involved, as well as pharmacists, patients and witnesses. It contains a range of offences for failing to comply. Unlike VAD laws in other jurisdictions internationally, the Victorian law prohibits health practitioners raising VAD with a patient and requires one of the two assessing doctors to have expertise in the relevant condition.

To date there has been a lack of Victorian research available to inform the implementation process. Published Victorian data is limited to two studies, both with small sample sizes. Surveys of support levels within particular specialties conducted across Australia give a limited understanding of the views of the Victorian clinicians for whom working in the context of legalised VAD is now a reality.

Given the multidisciplinary nature of the teams delivering health care in Victorian hospitals, collecting data from different types of clinicians enables greater insight into the potential effect of VAD on healthcare practice in Victoria. Taking a qualitative approach, asking open-ended questions of participants, facilitates the collection of data about what clinicians think is important, rather than limiting data collection to issues preidentified by researchers.

The aim of the present qualitative study was to identify the challenges that Victorian hospital-based clinical staff anticipate VAD will create in their work.

**Box 1. Key features of the *Voluntary Assisted Dying Act 2017* (Victoria)**

To access voluntary assisted dying (VAD), a patient must meet all of the following criteria:

- be an adult Australian citizen or permanent resident and reside in Victoria
- have decision-making capacity in relation to VAD
- have a medical condition that is incurable, advanced and progressive
- have a prognosis of no longer than 6 months (or 12 months in the case of neurodegenerative disease)
- be experiencing suffering caused by the relevant condition that cannot be relieved in a manner that the patient deems tolerable.

The patient needs to make at least three formal requests for VAD: a minimum of two verbal and one written.

For eligible patients, the medical practitioner will write a prescription for a lethal medication that the patient can ingest at a time of their choosing. For those patients who are unable to self-administer, the VAD medication can be administered by the physician.

The patient must be assessed by two medical practitioners.

- The medical practitioners must be either a vocationally registered general practitioner (GP) or a specialist and have completed the approved VAD assessment training.
- At least one must have held their specialist fellowship or be a vocationally registered GP for a minimum of 5 years.
- At least one must have expertise in the relevant condition.

Health practitioners can conscientiously object to participating in any or all of the processes involved in providing VAD.

Health practitioners must not initiate discussion about VAD with a patient, and must report colleagues who they reasonably believe have initiated such discussions.

**Methods**

The setting for this study was two healthcare services in Melbourne: a metropolitan tertiary referral health service (Service 1) and a major metropolitan health service (Service 2). Both were in the process of developing their local approaches to the legislative change at the time of the study. Victorian public hospitals each choose their level of involvement in the provision of VAD. For example, Catholic hospitals have indicated from the outset that they will not provide VAD. The two organisations in this study were exploring options and gathering staff
views to inform decision making. This survey was part of that process.

In order to gather data from a large number of clinicians in diverse roles, an anonymous online survey including free-text questions was used. The survey included information about the VAD legislation and 23 questions, five of which were free-text questions to collect qualitative data. The questions were developed via literature review and expert discussion within the research team, and were tested with the multidisciplinary VAD working group at one of the health services.

This paper reports on the qualitative data focused on challenges. Participants were specifically asked about challenges in one question, namely ‘What challenges (if any) do you envisage Voluntary Assisted Dying will create in your work?’

Some participants also provided data about challenges when responding to the other four qualitative questions, and these data were included in the analysis. The other four qualitative questions focused on the participant’s overall position on legalisation of VAD, reasons for being willing or unwilling to participate in VAD, supports needed for clinicians and an open question for any other comments on the issues raised in the survey.

Maximum variation sampling was used to ensure a wide variety of respondent characteristics and views were represented, because an overview of the phenomenon was sought. All types of clinical staff were included, recognising that clinicians work within multidisciplinary teams and that VAD will potentially have an effect beyond senior medical staff. Current clinical staff at these two health services (i.e. medical, nursing and allied health, including pastoral care and pharmacy) were eligible for inclusion in the study. The roles that are seen as ‘clinical staff’ may vary in different contexts. The roles included in this study reflect the use of the term at these organisations, where a direct therapeutic role in patient care is the critical element.

Participants were recruited via a link to the survey on the staff intranet and via emails to clinical staff lists with support from medical, nursing and allied health executive. The survey was open for approximately 3 weeks at each site during November 2018–January 2019, with reminder emails distributed on three occasions.

Data were analysed thematically using qualitative description. Three hundred participants from Service 1 and 200 participants from Service 2 were included in the initial phase of analysis. RM, BP, MS, BH and AH each independently coded a different data subset of 100 participants, then developed a shared coding framework through comparison and discussion of codes. The coding framework was then applied to the entire dataset (by BH, AH and CS), with further refinement of codes throughout the coding process, and grouping of codes into themes.

The study was approved by the Human Research Ethics Committee of Austin Health (Reference no. HREC/45754/ Austin/2018).

The research team included clinicians from both participating health services, alongside ethicists and qualitative researchers. There was a range of views within the team about the justifiability of VAD. Overall, the team’s position was one of neither advocating nor opposing the legislation itself; the team’s interest is in ethical implementation now that VAD is part of Victorian law.

### Results

In all, 1602 survey responses were collected. Levels of support or opposition to the VAD legislation for respondents from the two health services are specified in Table 1.

Of the 1602 total survey respondents, 1086 answered one or more of the free-text questions (774 from Service 1 and 312 from Service 2). The roles of the respondents who provided qualitative data are given in Table 2.

Clinicians anticipated a range of challenges associated with this legislative change. The challenges identified were similar across the two health services and included various types of burdens for staff, issues around organisational culture, the logistics of delivering VAD under the specific Victorian law and the relationship of VAD to the rest of the hospital’s work overall. Themes and illustrative quotes are provided in Table 3, with the participant’s role, health service (HS) and overall position on the legalisation of VAD in Victoria provided after the quote.

#### Burdens on individuals

Increased conflict was anticipated. There were worries about potential conflict in relation to colleagues, patients and families. This included fear of aggressive and threatening behaviour:

> I already receive abuse regarding the administration of medication to patients during end of life care. If medical staff deem a patient fit to make decisions about their uptake of VAD and the family disagree with the patient’s capacity I am concerned about aggression and family anger towards staff.
### Challenges anticipated by clinicians

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Quotes</th>
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<tr>
<td>Burdens on individuals</td>
<td>Great fear of divisions within teams, colleagues ‘judging’ one another (Senior doctor, HS2, unsure)</td>
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<tr>
<td>Increased conflict with colleagues, patients and families</td>
<td>Conflict between patient and clinician who doesn’t provide support for assisted death (Junior doctor, HS1, oppose)</td>
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<td>Workload</td>
<td>Discussing this with patients who wish to access VAD but do not fit in the criteria (Senior doctor, HS2, support)</td>
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<td>Finding the time necessary to evaluate a request, make an assessment, follow up the decision making process and coordinate the VAD (Senior doctor, HS1, support)</td>
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<td>The time needed to be with the patient and their family… I’m afraid on a busy ward day I still have 3 other patients to care for &amp; a whole bunch of documentation to do (Nurse, HS2, support)</td>
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<td>Increased workload without appropriate remuneration (Allied Health, HS1, support)</td>
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<td>Emotional burden</td>
<td>Emotional burden which may impact on ability to function well personally and professionally (Allied Health, HS2, unsure)</td>
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<td>I think I will find it emotionally burdensome to consult on a patient who is or has requested VAD as I will worry that I may second guess my management decisions and that if I do not relieve their symptoms, they may then choose to prematurely end their life (Senior doctor, HS1, oppose)</td>
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<td>Absorbing the immense emotional and physical workload it [VAD] would entail (Nurse, HS1, support)</td>
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<td>Organisational culture</td>
<td>I am most concerned about not having the right to be a conscientious objector to providing VAD (Junior doctor, HS1, oppose)</td>
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<td>Pressure to participate</td>
<td>I have concerns about becoming known as someone who facilitates VAD. In fact I would probably prefer that there was a confidentiality clause involved (Senior doctor, HS1, unsure)</td>
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<td>Privacy of participating clinicians</td>
<td>Staff will be recognised/singled out and people will see who supports it (Nurse, HS1, support)</td>
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<td>Discrimination against staff</td>
<td>Disagreeing with VAD should not be held against them by their employer (Nurse, HS2, support)</td>
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<td>Anyone with an opposing view will be dismissed as unfeeling and left to not voice their opinion for fear of discrimination (Senior doctor, HS1, oppose)</td>
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<td>[Need] allowances for staff to be able to decline their involvement with a VAD referral… without justification, discrimination or repercussion (Allied Health, HS1, unsure)</td>
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<td>Delivering VAD</td>
<td>Bed availability and transitioning patients through the hospital especially with how bed blocked the hospital is (Nurse, HS1, support)</td>
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<td>Logistics</td>
<td>The process does not ideally fit with the logistics of either inpatient work… or [outpatient] (Senior doctor, HS2, oppose)</td>
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<td>It [a VAD death] needs to be at a time when adequate support for everyone involved is available (Nurse, HS1, support)</td>
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<td>Prognosis determination is not always straightforward and is quite individualised (Senior doctor, HS2, unsure)</td>
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<td>Although capacity assessment in theory is ‘black and white’, in practice there are many grey areas (Senior doctor, HS2, unsure)</td>
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<td>Developing staff skill base</td>
<td>I think it will be a rare request in my area of practice so I anticipate having to refamiliarise myself with all aspects legal and practical whenever a request is made (Senior doctor, HS2, unsure)</td>
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<td>I am also concerned that if I am only doing this 1–2 times per year, I will never gain real competence in running it (Junior doctor, HS1, support)</td>
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<td>Equity of access</td>
<td>If we are not able to educate them that VAD exists or discuss it as an option, doesn’t that mean we are being biased in our medical service to those who are educated and knowledgeable? (Junior doctor, HS1, support)</td>
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<td>Ethical challenge of patients unaware of VAD legislation who are less able to seek this information (not IT literate, NESB [non-English-speaking background]) and not being able to freely talk of options (Senior doctor HS2, unsure)</td>
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<td>VAD within the hospital</td>
<td>The biggest challenge will be the ongoing misunderstanding that palliation equates to VAD (Junior doctor, HS2, support)</td>
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<td>Confusion between VAD and non-VAD care</td>
<td>Fear that junior and senior doctors will lose confidence in listening to and exploring patients’ distress close to the end of life for fear that either the patient will raise VAD which they will find uncomfortable, difficult and time consuming, or that they will be misinterpreted as having ‘initiated’ conversations re VAD (Senior doctor, HS2, unsure)</td>
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<td>Avoiding end-of-life care discussions</td>
<td>Patients feeling judged by their clinicians (Allied Health, HS2, oppose)</td>
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<td>Having other patients/families know I am participating in VAD – therefore undermining their trust in me if they are opposed to VAD (Nurse, HS2, support)</td>
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<td>Decreased trust</td>
<td>I am concerned about perceptions… there is the danger that patients and their families will consider that our primary focus has shifted from provid[ing] optimal care to assisting with death (Senior doctor, HS1, unsure)</td>
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<td>[VAD will] take away from palliative care resources (Junior doctor, HS1, oppose)</td>
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<td>Resourcing VAD</td>
<td>How will the organisation respond to the additional emotional/care burden to meet the needs of the VAD/other patients and staff wellbeing? (Nurse, HS1, support).</td>
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I already feel threatened and intimidated at times…I can only imagine what legalising VAD will do when families are not all on board with the decision made by the patient. (Nurse, HS1, unsure)

Alongside conflict, clinicians also anticipated challenges in relation to workload, particularly the time required for appropriate patient and family support, and for the necessary documentation.

The expected emotional toll for different groups in the hospital was also highlighted by participants. Participants identified emotional burdens both for objectors and for clinicians delivering VAD. In contrast, some participants suggested that emotional burden would be lessened when VAD was available:

…visiting the patients suitable for VAD causes far more stress and sadness compared with helping them terminate the torture. (Senior doctor, HS2, support)

Organisational culture

Overall, participants appeared fearful about being judged by other clinicians and management regarding their willingness to participate or not in VAD. Consistent respect for staff views was anticipated as a challenge. There were concerns about conscientious objection in practice, particularly about foreseen pressure on junior doctors and nurses to participate:

Technically you can opt out of participating in VAD but how will that go down practically as a junior doctor if your consultant is the one coordinating things? (Junior doctor, HS1, unsure)

Staff having pressure put on them by management and other staff to perform things that they aren’t comfortable with. (Nurse, HS2, oppose)

Other anticipated challenges in organisational culture were protecting the privacy of clinicians who chose to be involved in VAD, and preventing discrimination in the workplace based on a staff member’s position on VAD.

Delivering VAD

Clinicians identified various logistical challenges that would be associated with delivering VAD in the hospital. These included an appropriate location, bed availability, timing of death, the length of the approval process, storage and handling of the medication, differences in prognosis by different doctors and difficulties in assessing a patient’s decision-making capacity. Clinicians also anticipated that the delivery of VAD-related care would be complicated by legal complexity and uncertainty. However, these practical challenges were not always prioritised:

The challenges I foresee would be primarily emotional rather than practical. (Junior doctor, HS1, unsure)

There were also concerns about equity of access and about developing staff skills in VAD given that it is likely to be a rare occurrence. Equity of access was anticipated as a challenge in the context of the prohibition on clinicians raising VAD:

legislating against free open discussions with our patients is wrong. How do we consent for anything – e.g. chemo v. palliative care v. VAD – if we cannot establish that the patient knows their legal options, because we cannot explore at all their knowledge that VAD is an option. This puts the most vulnerable in our community at disadvantage. (Senior doctor, HS2, unsure)

Equity concerns were raised about eligible patients with, for example, low literacy or Internet skills or from non-English speaking backgrounds.

VAD within the hospital

Clinicians perceived challenges in integrating VAD into the care provided by the hospital. One anticipated challenge was confusing patients and families in relation to other aspects of end-of-life care:

…family members at a distressing time thinking that normal symptom management in end of life care is VAD. (Nurse, HS1, oppose)

This was seen as particularly likely for some cultural groups:

…given the cultural backgrounds of many of our patients, withdrawing treatment that does not prolong life or relieve suffering is quite a challenge at times. Introducing VAD into the equation, where patients and families do not actually understand the difference between withdrawal of treatment and VAD will be difficult. It is also likely that some patients or families will not understand the difference between VAD and palliative treatments. (Senior doctor, HS2, oppose)

There was also concern that medical staff may avoid end-of-life care discussions because of the increased complexity that the availability of VAD creates, for example being misinterpreted as having initiated a VAD discussion.

Some participants anticipated that the legalisation of VAD would decrease trust in health professionals, particularly in palliative care. Resourcing was also identified as a challenge. There was concern that:

…[VAD would] come at the detriment of other patients’ needs, if not adequately staffed and resourced. (Junior doctor, HS2, support)

Discussion

In this study, challenges associated with VAD were anticipated across all clinical roles in the hospital and for both objectors and supporters of VAD. These varied from individual burdens such as emotional distress to complex systemic issues such as equity of access and resourcing VAD. Many of the individual burdens anticipated by Victorian clinicians in this study are similar to those in the existing international literature. Studies document the challenges experienced by physicians and nurses following legalisation of VAD in countries including Canada, Belgium and the Netherlands and parts of the US: emotional burden, conflict between parties involved in VAD decision making, including strained relationships between colleagues, workload, fear of legal vulnerability and stigma.\(^{2,11-17}\)

Importantly, the present study also identified challenges that clinicians foresee in relation to integrating VAD within existing health systems. The challenges falling under the two themes ‘delivering VAD’ and ‘VAD within the hospital’ are issues faced by hospitals, health services and health systems rather than
difficulties that individual clinicians will experience. This wider focus likely reflects the timing of the study in the preimplementation phase for the Victorian legislation; the data were collected after the law had passed but before the starting date for VAD. This is different to the majority of research in this area, which focuses either on clinicians’ views before legalisation or on clinicians’ experiences once VAD is part of practice.\textsuperscript{5,6,10} In this preimplementation phase, clinicians anticipated a range of challenges for all types of individual practitioners in their work, but also a set of challenges for hospitals, health services and health systems in attempting to integrate VAD into existing healthcare structures.

The findings of this study will benefit other jurisdictions considering legalising VAD, as well as the Victorian health services currently dealing with this legislative change. Although these results pertain to two Melbourne health services and are limited to those clinicians who chose to participate in research on this sensitive topic, many findings are similar to research from other jurisdictions where VAD is permitted. Thus, the results are likely to be relevant more widely: around Victoria, in other jurisdictions with VAD legislation and in jurisdictions where legislation is being considered. Understanding and addressing this set of anticipated challenges in Victoria will be important in supporting clinicians locally, and will potentially be helpful in the design of VAD legislation or associated clinician education elsewhere.

Conclusions

The legalisation of VAD is perceived as a substantial shift in health care, creating a range of challenges for all types of clinicians in the hospital setting. To adequately support clinicians in the context of this change, careful attention is needed to the breadth of staff affected and the range of challenges faced. Given some unique features of the Victorian legislation and the potential for VAD legislation in other Australian states and territories, understanding the Victorian experience is crucial. It will be important to continue to research clinicians’ experiences to understand whether and how these anticipated challenges evolve in practice once VAD is legal in Victoria.

Competing interests

Danielle Ko is a member of the Victorian Voluntary Assisted Dying Review Board. This work was undertaken in her capacity as a palliative care and clinical ethics researcher, and not as a member of the Board. Any views expressed in this paper are Dr Ko’s personal views and are not to be attributed to the Review Board. The other authors have no relevant disclosures.

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