What the Doctor Would Prescribe: Physician Experiences of Providing Voluntary Assisted Dying in Australia

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Abstract

Background: Like many countries where voluntary assisted dying (VAD) is legal, eligible doctors in Victoria, Australia, have sole legal authority to provide it. Doctors’ attitudes towards legalised VAD have direct bearing on their willingness to participate in VAD and consequently, on whether permissive laws can effectively facilitate access to VAD. The study aimed to explore how some Victorian doctors are perceiving and experiencing the provision of legalised VAD under a recently commenced law.

Methods: Semi-structured interviews with 25 Victorian doctors with no in-principle objection to legalised VAD were conducted between July 2019-February 2020. Interviews were recorded, transcribed, and analysed using thematic analysis. Ethical approval from the relevant institution was obtained.

Results: Doctors perceive or experience VAD to fundamentally challenge traditional medical practice. Barriers to access to VAD derive from applicant, communication, and doctor-related factors. Doctors’ willingness to participate in VAD is situation specific.

Keywords: euthanasia, access to health care, clinical decision making, end-of-life, assisted suicide

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After more than 50 attempts at law reform in various Australian jurisdictions over the past two decades (Willmott et al., 2016) the Australian state of Victoria commenced legal voluntary assisted dying (VAD) on 19 June 2019. VAD became lawful in a second Australian state, Western Australia, on 1 July 2021 and other states are likely to follow. These reforms reflect wider international trends with legalisation of VAD also imminent in, for example, New Zealand, Spain, and Portugal. The Victorian law (VAD Act) permits adults who meet specified eligibility criteria, resident in that state, to request assistance from doctors to die. The person must have decision-making capacity in respect of VAD, and the request must be enduring, voluntary, and free of coercion. Following assessment by two doctors, and the issue of a relevant permit, the process culminates in the prescribing of a VAD substance to a person for self-administration (sometimes referred to as physician-assisted suicide). Practitioner administration of VAD, where a doctor intravenously administers the substance (sometimes referred to as voluntary euthanasia), is permitted only if the person is physically unable to ingest or digest the substance.

Like many of the VAD systems operating around the world, the only authorised providers of VAD in Victoria are physicians. Victorian doctors can conscientiously object to participating in VAD, and they are not required to refer a request on to another physician. Access to VAD in Victoria and other locations where physicians are exclusive providers, is thus contingent on their willingness to provide it (Emanuel et al., 2016; Lee et al., 2009; Oliver et al., 2017). Doctors tend to be more opposed to legalised VAD than the broader community (Emanuel et al., 2016; Gielen et al., 2008; McCormack et al., 2012) although there is evidence that this opposition is declining (Torjesen, 2020) as the legalisation of VAD around the world continues apace.

Prior to commencement of its VAD law, the Victorian Government anticipated that approximately a dozen people would have a voluntary assisted death in the law’s first year of operation (Andrews, 2017). Recent government reporting indicates that from 19 June 2019, when the VAD Act commenced, to 30 June 2020, 124 people died under a VAD permit. An additional 217 people had initiated the VAD process with a first medical assessment (Voluntary Assisted Dying Review Board, 2020). Despite this significantly higher than expected use of the law, the Australian media reports intending applicants experience barriers to accessing VAD (Cunningham, 2020a, 2020c). The most heavily reported barrier to access is an inability to locate a doctor willing to provide VAD (McDougall & Pratt, 2020; Moore et al., 2020). This corresponds with similar reports from other jurisdictions where VAD is legal (Brown et al., 2020; Ganzini et al., 2001; Harman & Magnus, 2017).

It is known that few physicians choose to participate in VAD after it has been made legal (Harman & Magnus, 2017; Karapetis et al., 2018; Sercu et al., 2012). Some doctors hold a conscientious objection; others are disincentivised by the increased workload, fear, and emotional toll that being a provider of VAD may entail (Bouthillier & Opatrny, 2019; Lo, 2018; Otte et al., 2017). Early evidence
from Victoria shows that out of approximately 28,700 licenced physicians, 175 (0.6%) had registered as VAD providers by 30 June 2020 (Voluntary Assisted Dying Review Board, 2020).

**Methods**

This study aimed to explore the attitudes and experiences of some Victorian physicians of their new role as VAD providers during the first twelve months of the law. It is among the first empirical research about VAD emerging from Australia since the legalisation of VAD in that country for the first time in over 20 years. The research was a qualitative study involving semi-structured interviews with twenty-five Victorian doctors.

**Sampling and Recruitment**

The study included Victorian doctors likely to receive a request for VAD. Purposive sampling targeted doctors from medical specialities that generally deal with end-of-life populations. These specialities include oncology, nephrology, geriatric medicine, palliative medicine, general practice (family medicine), cardiology, neurology, internal medicine, and intensive care. The exclusion criterion was in-principle objection to legalised VAD. Recruitment commenced by an electronic search for the contact details of Victorian physicians falling within one of the targeted specialities. Public contact details of approximately 125 physicians were identified from this electronic search, and initial contact messages were sent to the publicly available email address. A follow-up email was sent two weeks later. Upon a positive response to the recruitment email, the exclusion criterion was applied during further email or telephone correspondence. Initial purposive sampling yielded a low response rate (12 positive responses from 125 initial contacts), which was sufficient to commence the interview study. It was later supplemented by snowball sampling which recruited the remaining interview participants. Participants provided informed consent prior to the commencement of the interview, and participation was confidential and unremunerated.

**Data Collection and Analysis**

Interviews were conducted by JR using a piloted interview guide developed with LW and BW and informed by evidence from the field. Interviews canvassed participants’ understanding of, and experience with operating, the *VAD Act*, as well as their degree of willingness to participate in VAD, and issues they perceived or experienced with their legal role. Interviews were conducted face-to-face, apart from two phone interviews, and lasted for between 30 minutes and two and a half hours. Interviews were transcribed by JR using transcription software. Transcripts were thematically analysed in NVivo 11.0. The use of in-vivo, structural and evaluation coding strategies strengthened research
validity and rigour. LW and BW reviewed coding and categorisation methods and interim research findings.

Results

Participant Characteristics

Over half the participants were male, based in metropolitan Melbourne, and had more than 20 years of experience as a physician. Table 1 reports participant demographics. Age and religious denomination data were not collected.

Thematic Analysis

The VAD Act had been in operation for less than three months at the time of some interviews and only one-third of interviewees had actively (e.g., more than mere information provision about VAD) participated in VAD by the time of

Table 1. Participant Data.

| Participant demographics | Number (n = 25) | Total (%) |
|--------------------------|----------------|-----------|
| Years of practice        |                |           |
| 5–10                     | 4              | 16        |
| 10–15                    | 5              | 20        |
| 15–20                    | 3              | 12        |
| 20–30                    | 2              | 8         |
| 30–40                    | 8              | 32        |
| 40+                      | 3              | 12        |
| Gender                   |                |           |
| Female                   | 8              | 32        |
| Male                     | 17             | 68        |
| Clinical speciality      |                |           |
| Geriatric medicine       | 5              | 20        |
| Oncology                 | 4              | 16        |
| General practice         | 7              | 28        |
| Palliative medicine      | 3              | 12        |
| Nephrology               | 2              | 8         |
| Cardiology               | 1              | 4         |
| Neurology                | 1              | 4         |
| Internal medicine        | 1              | 4         |
| Intensive care           | 1              | 4         |
| Location of practice     |                |           |
| Metropolitan             | 11             | 44        |
| Outer metropolitan (≥20 km from central business district) | 4 | 16 |
| Regional (≥100 Km from central business district) | 10 | 40 |
Rutherford et al. Within this context, key themes from participant perspectives and experiences of legalised VAD include: VAD fundamentally challenges medical practice; barriers to VAD access include applicant, communication, and doctor factors; and doctors’ willingness to participate in VAD is situation specific. Each of these themes is discussed further below and Figure 1 provides an overview.

**VAD Fundamentally Challenges Medical Practice**

Participants report and reflect on the challenge that VAD presents to typical medical practice. An implication of this theme is that doctors may elect not to

![Driver Diagram of Themes From Interviews](image)

**Figure 1.** Driver Diagram of Themes From Interviews.
participate in VAD owing to the difficulties they may face through their involvement. Participants perceive and experience this challenge through what they report to be the failure of the broader medical profession to embrace or endorse the practice of VAD. Many influential national and international professional associations continue their opposition to legalisation of VAD (Australia Medical Association, 2016; World Medical Association, 2013), and there is little guidance provided by professional bodies to support physicians who choose to work in this space. In the absence of professional guidance, participants report having to individually determine the way they participate in VAD. They report the need to define their own scopes of practice as they engage in complex negotiations around VAD applications with colleagues and health institutions alike, which has led to some degree of conflict. Participants are alert to the potential for reputational stigma that might emerge from their provision of VAD. Some participants attribute their profession's muted response to VAD to its collective belief that VAD does not form part of medical practice. This tension underpins one of the most enduring professional challenges raised by participants – practising palliative medicine in the era of VAD. Additionally, participants report difficulty with interpreting the VAD Act, which must be done within significant resource constraints they do not experience in other aspects of their medical practice. Participants report a lack of time, remuneration, and support systems when participating in VAD.

Response by Medical Profession

“There seems to be a cohort of doctors who have said, No, I’m having nothing to do with it. A cohort of doctors who say I’m supportive. A cohort who says, I’m supportive, and I’m prepared to do it, and the very, very, very small proportion who have actually completed the training requirements and are actually physically prepared to put pen to paper and follow through with it.” [Participant 24]

Participants report that most of their colleagues are not involved in VAD. They attribute this to conscientious objection or, where colleagues might support VAD in-principle, a sense that ‘someone else can do it’. Participants also report the experience of varying degrees of conflict around their provision of VAD, which can result in covert or overt obstruction by opposing colleagues.

“Some of the roadblocks in getting a framework bedded down are from clinicians themselves. The palliative care physician who’s the head of [major tertiary hospital] unit is very opposed... there was a patient who sought VAD within that hospital, and [unit head] wouldn’t allow it to happen there so moved that patient to a very peripheral hospital disconnected from family and friends. I suspect those things are happening not uncommonly.” [Participant 25]
One participant speaks to the potential for a commercial conflict of interest to arise in the context of patient referrals for VAD.

“If you’re in a competitive [referral] area, and one GP is sending you all their business for all of their new diagnoses of malignant cancer, and then they send you someone who they’ve deemed eligible who you actually don’t think is eligible, that creates this conflict between your business provider, your customer… who determines where the business goes...So you can’t say that there’s no pressure there in terms of independence of opinion.” [Participant 17]

Participants also report the conflict they experience or witness in institutional settings. One participant reports that a colleague opposed to VAD refused to be on call for VAD patients in a palliative care ward, potentially impairing continuity of care for patients seeking access to VAD. Participants also raise concerns about the reputational impact of participating in VAD.

“One of the [practice] owners called me the Grim Reaper for a while. That wasn’t much fun when he found out about it.” [Participant 4]

**Incompatibility with Palliative Care**

Another professional challenge perceived by participants is VAD’s potential to clash with the practice of palliative care. Some of the study participants are palliative medicine specialists who express concern about the potential for reduced referrals to palliative care following the legalisation of VAD, from doctors or patients opposed to VAD who might assume it is part of palliative medicine. Some participants assert the need to maintain a bright-line distinction between VAD and palliative care.

“It’s affecting us in palliative medicine, more than we would like and more than it should because of the assumption that because we specialise in end-of-life care, therefore, this is for us. And so, the general perception amongst medical practitioners, the health community and the general public is that this is our thing. And so, for a lot of us, we’re saying, no, this is not our thing. So, that’s been challenging.” [Participant 24]

**Interpreting and Applying the Law**

Participants report a significant challenge in how to understand and apply the VAD law. Trying to make a complex law work in the context of their own medical practice is a common theme in participant data.

“I think the legal overtones and implications make practising [VAD], particularly for general practitioners, indeed a bit anxious.” [Participant 5]
Certain provisions of the law are seen by participants to lack clarity, such as how to prognosticate life expectancy (which under the VAD Act must be six months or less, or twelve months in the case of neuro-degenerative conditions), or how to assess legal requirements for decision-making capacity for VAD and the voluntary nature of a person’s request.

**Lack of Resources**

Participants also point to how the implementation of the VAD Act requires significant resourcing including time, money, institutional supports, and peer networks. Yet these supports are not readily available to participants who provide VAD, so they must make do with the resources they can corral from other areas of their medical practice. Participants report that coordinating a VAD application through to the patient’s death equates to about sixty hours of working time.

Participants grapple with how to combine their new provision of VAD with the workload of an already time-poor doctor. Some participants report undertaking VAD assessments without their preferred degree of comprehensiveness because of time constraints, for example having to assess acute patients in busy hospital environments rather than in the more conductive environs of their consulting rooms. Others report not being able to see their usual patients because of the VAD workload they have accumulated as one of a handful of participating physicians. Participants additionally report that much of the work they do around VAD is unremunerated, which, while not precluding them from their present involvement, might serve to disincentivise them in the future. Participants also identify disparate resourcing of the support networks they need, with some experiencing a sense of professional isolation, without peer support or adequate clinical guidelines.

**Barriers to Access Include Applicant, Communication, and Doctor Factors**

Participants provide insights into aspects of the Victorian VAD system that they consider might facilitate access barriers. One of these is a shortage of willing doctors. Participants point to the option for conscientious objection, a mandatory training requirement for VAD providers contained in the Victorian law, and the ineligibility of junior doctors to participate, as causes of doctor shortages. Participants also note communication-related issues specific to the Victorian legislation, which contains a novel provision banning doctors from raising the topic of VAD with their patients. Additionally, owing to a potential conflict between state and federal laws, the Victorian Government has directed VAD providers to only communicate face-to-face about VAD, thereby preventing the use of telephone, email, and telehealth for VAD work (Victorian
According to participants, arbitrary time-based life expectancy requirements contained in the VAD Act also function to make some people with intolerable physical suffering ineligible.

**Applicant Barriers**

Participants express concern with the VAD Act’s strict eligibility criteria, which restricts access to persons who have a disease, illness or medical condition that is incurable, advanced, progressive and will cause death within weeks or months, not exceeding six months (or twelve months in the case of neuro-degenerative conditions).

“I think that it is overly restrictive, because that pretty much guarantees one type of patient – its guaranteeing cancer patients at the end of their life, not many others.” [Participant 3]

The requirement in the Victorian law for the qualifying condition to be incurable also concerns some participants, who express uncertainty about determining this when the possibility of life-extending or experimental treatments exists. The complexity of the eligibility criteria is reported by many participants to make them feel uncomfortable putting their name to a decision that has such far-reaching consequences.

Participants report that place of residence is another applicant factor that can function as an access barrier. Victorian doctors are currently not permitted to utilise telehealth for VAD appointments, which particularly impacts access for rural and regional applicants, who must then travel - potentially while gravely ill – to meet with medical specialists generally resident in metropolitan areas.

“A case in [rural location 4 hours away] where the lady had a high output stoma, so she had to stop every 20 minutes to empty out her bag. So, we’re putting her in a car getting her to come down to [town] because this was the only centre that could provide her with VAD.” [Participant 3]

**Communication Barriers**

Participants regularly emphasise the importance of good communication and relationships during the VAD process, and all participants raise concerns with various aspects of the VAD Act which inhibit conducive discussion. These aspects include a legal prohibition in Victoria against doctors raising VAD with their patients, which is a novel provision not contained in any other operative VAD law.

“All of this assumes a degree of health literacy, which I think is unreasonable... It may lead to an unfortunate situation where a patient is trying to ask for it, but is not able to use the words, and the doctor can’t check what your meaning was.
It’s the only thing in medicine where you’re not allowed to do that. It’s a very unusual thing.” [Participant 6]

This prohibition, combined with a legal direction to only communicate face-to-face about VAD, means that some participants perceive a ‘veil of silence’ around VAD in Victoria, leading to a difficulty (for both applicants and doctors) locating VAD providers, and a sense of professional isolation for doctors providing VAD.

**Doctor Barriers**

Victorian doctors are required to undertake mandatory legal training before they can participate in VAD. Participants report that this requirement, and another provision requiring one of the two assessing doctors to be a specialist in the qualifying medical condition, narrows the field of doctors available to act as VAD providers, and therefore increases barriers to access. Additionally, some participants express concern that doctors who invoke the conscientious objection protections are not legally required to refer the patient onto another doctor, possibly risking patient abandonment.

Participants report that the requirement for mandatory training (which takes between six-eight hours of online training followed by a compulsory exam) is the “number one deterrent” for doctors to participate in VAD. They allude to the training’s unremunerated nature, their lack of time, and the training’s lack of practical clinical guidance.

The *VAD Act* requires one of the two participating doctors to hold “relevant expertise and experience” in the applicant’s medical condition, meaning junior doctors cannot participate. This is a novel provision amongst the international laws. An associated issue is the requirement for the medical specialist contributing that expert opinion to have undertaken the mandatory VAD training, which limits the pool of available physicians.

“If a respiratory physician who didn’t have the training said that this person had less than six months left to live, it seems to me to be crazy that we have to actually find a respiratory physician who’s done the training to say, ‘they’ve only got six months’ to give the consultant opinion.”[Participant 12]

The conscientious objection provisions contained in the *VAD Act* are perceived by participants to create access barriers, both in terms of limiting the number of doctors available to participate in VAD, and that doctors with a conscientious objection are not required to provide information about VAD to patients who might enquire, nor are they required to refer those patients onto a known provider.

“I think the problem with [conscientious objection] is because of the lack of awareness of doctors who provide VAD services and VAD assessments, is that that may
leave the patient in purgatory in terms of not knowing where to go next.”
[Participant 17]

**Doctors’ Willingness to Participate is Situation Specific**

Doctors’ willingness to participate in VAD has implications for access under the Victorian system. This is reflected in participant data regarding a sliding scale of willingness to participate in VAD, which tapers sharply at practitioner administration. While most participants identify factors which may disincentivise doctors from participation in VAD, a few also report situations which may motivate them to participate in VAD. These include achieving ethical resolve; a catalyst patient; repeated VAD participation becoming less fraught; and personal benefit.

**Sliding Scale of Willingness**

Some participants report a strong preference to be involved in VAD tasks that more closely resemble typical medical practice. Thus, they are usually more willing to provide information, and assess medical eligibility.

“The two consultants I have had contact with as part of this have been more than okay in doing their assessment, but they weren’t at all keen to do anything more than that. And one of them, in fact, was the oncologist of the patient and they still wanted me to be the coordinating doctor.” [Participant 10]

Rationales given by study participants for their preference for these more limited VAD roles include lesser time commitment, clinical complexity, and emotional involvement.

“Our hospital did a survey where we were asked about [VAD]. And the first question was about do you think the Act is a good thing? And for that first question, the doctors and the rest of the staff are very much of the same opinion, that it’s a good thing. But as you come down to doctors having to do more and more of it, support drops off. And it’s that thing about the more involvement that you have, the more difficult it is to do it.” [Participant 6]

In this study, of the doctors willing to participate in VAD, most have no problem with being required to prescribe a VAD substance for self-administration. More unwillingness emerges around their presence at a self-administered death. Some participants do not routinely offer to be present, concerned at the additional time and emotional commitment. Others offer this service in the belief they need to attend in case something goes wrong with the self-administration.
Practitioner Administration

Many participants evince an intention to be involved in ‘everything but’ practitioner administration (in other words, not being responsible for the ultimate act of causing a person to die).

“Philosophically speaking, I would probably draw the line. I probably would not push through medication intravenously personally.” [Participant 1]

All participants support a doctors’ prerogative not to provide practitioner administration. Of the participants who have provided practitioner administration, all indicate the difficulty inherent in the role. These participants note the need to take time away from VAD duties afterwards, ranging from days to weeks, and that it is not a service that they wish to regularly provide. Some of them report not having the requisite technical skills to place an intravenous line for the practitioner administration.

“I’m an old Doc. I don’t put drips in. I’d last done one 30 years ago. So, when it became obvious, I said to the guy that he’d either need to have a drip put in by the palliative care service, which I don’t think they were really all that keen on doing, or that I can try it. So, he sat in that chair there, and I tried it on him, got it in the second time. This was about a week and a half before I finally did it to him in his own house which took about six shots. So, under pressure I wasn’t that good at it, so it was a bit painful for him.” [Participant 4]

Incentives to Participation

One participant reports that he was initially opposed to the law and took a public stance against it, but upon legalisation decided he was obligated to provide VAD because it was then a patient’s legal right. Other participants report being the ‘last person standing’ as their colleagues decline involvement.

Participants equate their support for VAD with medical bioethical principles but report a struggle to reconcile their position of conscience with opposition from the broader medical profession. Some participants report the influence of a ‘catalyst’ patient that might serve to crystallise their involvement in VAD. Participants characterise a catalyst patient as a person who ticks all the boxes for eligibility, or a long-standing patient, or one who is so adamant in their request that it compels a doctor to settle their position. Some participants who have provided VAD speak to how repeated participation becomes less fraught, or at least does not serve to disincline them from practice.

“It was easier the second time round. The night before it was not much sleep, but it was more the practicalities of it, what if the line goes wrong, what if something’s not working.” [Participant 12]
Participants also speak to the personal value that accrues from their involvement in VAD. Some have been long-time supporters of law reform and so benefit from being able to act in accordance with their beliefs. For other participants, the gratitude they receive from patients and their families incentivise them to stay involved.

“It is a positive thing to do for people. It’s brought me a lot of personal reward. It’s seen as valid, valuable. I’ve been in obituaries, and I’ve been in eulogies and thanked more in these months of VAD than I think I have been as an oncologist...It is a very rewarding thing to be a part of.” [Participant 17]

Discussion

The Victorian VAD system largely follows a model already established around the world – provision solely by doctors, exercising their medical professional judgement under various legislative constraints. The implicit risk with these models is presumption of a sufficient supply of doctors willing to provide VAD. For this reason, the perspectives and experiences of doctors are crucial to evaluation of VAD systems. Participants in this study have reported the fundamental challenge that VAD presents to medical practice, the access barriers they perceive, and the situation specific nature of their willingness to provide VAD.

Participants reported that their profession’s lack of support for their participation in VAD complicates their provision of VAD. Evidence suggests that the orientation of professional medical associations is critical to the successful implementation of VAD (Seale, 2009). It has been suggested that in a post-legalisation context, the proper role of professional medical associations is to contribute to those areas where they have expertise – for example, advising on the necessary safeguards, codes of practice and on matters such as assessing prognosis and setting guidelines for end-of-life care (Tallis, 2012).

Collegial and institutional conflict is one manifestation of the challenge that VAD presents to medical practice and has been well documented in existing VAD implementation studies (Beuthin et al., 2020; Bouthillier & Opatrny, 2019; Brown et al., 2020; Fujioka et al., 2019; Harman & Magnus, 2017; Khoshnood et al., 2018; Shaw et al., 2018). An oncologist participant in this study reported a new variant of conflict around VAD – the potential for commercial conflict of interest, where treating doctors make referrals for VAD assessment to specialist consultants who rely on them for other patient referrals, making the specialist wary about providing a conflicting opinion regarding VAD eligibility.

As participants attested, the decision to provide what is considered by many in the medical profession to be a fringe or taboo practice has the perceived potential for stigma. Existing studies have noted concerns from VAD providers
about unwanted publicity and reputational damage, with 58% of Oregonian VAD prescribers being concerned about being labelled a “Kevorkian” (Ganzini et al., 2000, 2001).

Another dimension of the challenge to medical practice reported by participants is its perceived incompatibility with palliative care. The ongoing tension between the two practices is widely observed in the literature (Belanger et al., 2019; Bernheim, 2008; Chambaere & Bernheim, 2015; Materstvedt, 2013). Palliative care doctors are opposed to legalised VAD at higher numbers than other medical specialities, owing to concerns about scopes of practice, patient trust, and a feared decline in palliative care resourcing and standards following legalisation of VAD (Galushko et al., 2016; Lavoie et al., 2015; Sheahan, 2016; Zenz et al., 2015). Participant concerns about reduced palliative care referrals are consistent with population-based studies demonstrating a public misconception associating VAD with palliative care (Kozlov et al., 2018; Patel & Lyons, 2020; Shalev et al., 2018). Yet, international evidence also suggests that an overwhelming majority of VAD patients receive palliative care services before their death (Health Canada, 2020).

Another challenge to medical practice reported by participants is how to interpret VAD laws which many of them regard as very complex. One study of Dutch VAD providers found that legal criteria were sometimes incorrectly understood and differentially applied, with significant variation in eligibility decisions (ten Cate et al., 2017). Another study found that VAD providers experience strong pressure from the responsibility of interpreting the ‘open norms’ of VAD laws, such as the criteria for suffering or the incurability of the qualifying condition (de Boer et al., 2019).

Doctors’ role in applying the law is complicated by the lack of time, financial and support resources available to them to achieve this in practice. A lack of these resources is observed in the literature as a factor disincentivising doctors from involvement in VAD (Brooks, 2019; Fujioka et al., 2018; Kelly et al., 2020; Khoshnood et al., 2018). VAD implementation studies in Canada and the United States have emphasised the critical nature of peer and institutional supports for doctor providers (Brown et al., 2020; Harman & Magnus, 2017; Shaw et al., 2018). One participant spoke of how their first experience of providing practitioner administration was made easier by having a nurse practitioner in attendance at the death and receiving a phone call from their institution’s chief medical officer shortly afterwards to offer support. These types of structural supports are vital, yet there are mixed reports from participants regarding the level of preparedness of Victorian health institutions for VAD. The provision of appropriate guidelines and procedures are noted in the literature as being highly correlated to doctors’ willingness to participate in VAD (Haley & Lee, 1998; Hesselink et al., 2010).

Existing evidence is that a lack of a sufficient corpus of willing doctors presents a threat to the sustainability of VAD systems that situate doctors as
exclusive providers (Abrahao et al., 2016; Dickinson et al., 2002; Emanuel et al., 2016; Ganzini et al., 2000, 2001; Harman & Magnus, 2017; Karapetis et al., 2018). A lack of willing doctors is one access barrier which participants identified, in addition to a variety of applicant and communication-related barriers. Participants reported that place of residence can significantly impair access, consistent with studies in Canada and Oregon which have also observed that access to VAD depends significantly on geography (Downar & Francescutti, 2017; Ganzini et al., 1996; Khoshnood et al., 2018). Regulatory and media reporting suggests that regionally based Victorian residents continue to have trouble trying to locate a trained VAD provider (Cunningham, 2020b, 2020c; Voluntary Assisted Dying Review Board, 2020). While a shortage of doctors in non-metropolitan areas is not a situation unique to the VAD context, there are additional factors such as reputational stigma that might come into play for rural and regional doctors who are contemplating participation in VAD (McDougall & Pratt, 2020).

Fettering of communication about VAD, such as the Victorian provision which bans doctors from raising VAD with their patients, can also create access barriers. Concerns have been expressed about the effect of such a prohibition on the quality of communication between doctors and their patients (Willmott et al., 2020). The Victorian Government’s rationale for this provision was to ensure a VAD request from a person is voluntary and free from coercion (Victorian Ministerial Advisory Panel, 2017). Participants generally disagreed with this rationale, questioning the capability of applicants to voluntarily raise VAD when there are issues of health literacy, incomplete disclosure of medical treatment options, and the unfairness of requiring gravely ill persons to both be aware of their legal obligation to raise the issue first, and physically able to communicate their request.

Factors which can lessen doctor participation and therefore impair access are reported by participants to include the complexity of the VAD Act and fear of legal repercussions, a deficit of time available to undertake the mandatory training, inadequate training, qualifications on the types of doctors who can participate, and statutory protections for conscientious objection. Lack of appropriate training in VAD and end-of-life issues is universally reported, leaving doctors ill equipped to communicate about options and manage VAD requests (Buiting et al., 2008, 2009; van Marwijk et al., 2007). Concerns about the conscientious objection provisions of VAD laws are already reported (Chochinov & Frazee, 2016; Harman & Magnus, 2017). A related aspect of conscientious objection provisions in VAD systems where doctors are the exclusive providers, is the creation of unsustainable workloads for those who choose to provide VAD (Bouthillier & Opatrny, 2019). Some VAD providers in this study attested to the loss of personal and family time, as well as the mental fortitude and emotional resilience that is required of them where only a small cohort of VAD providers exist.
There remains a large gap between intended and actual participation in VAD by doctors (Beuthin et al., 2020; Bouthillier & Opatrny, 2019; Yoong et al., 2018). Participants in this study are Victorian doctors with no in-principle objection to legalised VAD, yet report their willingness to provide VAD is situation specific and conditioned by a preference for lesser involvement, which is consistent with international evidence (Karapetis et al., 2018; Oliver et al., 2017). There is also evidence that doctors’ willingness to participate in VAD decreases over time. A Quebec study found that while about 66% of physicians had initially indicated willingness to participate, about 60% were unwilling to participate when resurveyed 18 months after legalisation, largely due to the emotional and clinical burden (Bouthillier & Opatrny, 2019). There is also literature on the ‘moral distress’ that doctors face when dealing with a VAD application which may disincline them from further practice (Dobscha et al., 2004; Kelly et al., 2020; van Marwijk et al., 2007). These indicate the potential lack of sustainability of VAD regimes unless a better understanding of the factors supporting doctor involvement in VAD is developed. Motivating factors are reported by participants to include ethical resolve and confidence in their clinical skills (including intravenous administration) to perform VAD (Curry et al., 2000; Groenewoud et al., 2000; Lavoie et al., 2015; Rutherford, 2020; Sercu et al., 2012). Literature also reports that some VAD providers experience their participation as rewarding and beneficial (Beuthin et al., 2020).

While achieving ethical reconciliation is important, it is not enough to guarantee involvement. Ethical imperatives - even where they form a core set of professional values and identity – appear highly contingent on other motivating factors, such as the personal backgrounds or organisational contexts that doctors function within (Rutherford, 2020). The concept of a ‘catalyst’ patient mentioned by some participants as an incentive to participation has not been examined closely in the literature. Existing literature describes how an adamant patient request can cause the doctor to feel pressure to comply (Georges et al., 2008; Snijdewind et al., 2018; van Marwijk et al., 2007) although it should also be noted that an adamant request, or one which is communicated by a person in an overly entitled manner, can disincline doctors from participation (Snijdewind et al., 2018). A relatively straightforward VAD application, where the person ‘ticks all the boxes’, or, in other words is not a ‘hard case’ might be an incentive to participate.

**Implications for Policy and Practice**

A major implication that has been determined from this study into some Victorian doctors’ perspectives and experiences of the VAD Act is a potential shortage of doctors willing to participate in the VAD regime. This is not only a present risk but a future one if participating doctors become disincetivised by workload, emotional toll, or professional conflict. To support a viable supply of
participating VAD providers, each of the themes explored in this study suggest useful strategies. The thematic finding of VAD’s fundamental challenge to medical practice suggests that the medical profession needs to resolve some of the professional conflicts that the newly regulated practice of VAD is causing it at both a collective and individual physician level. Without the assistance of their representative professional bodies, doctors must individually determine the type and extent of their own medical practice of VAD. Medical colleges and associations should supply professional practice guidelines, codes and/or advice to help safeguard both doctors and patients in the VAD process (Hesselink et al., 2010; Tallis, 2012). Reporting by participants of the lack of constructive engagement by their profession regarding VAD suggests that the debate around whether VAD is part of medical practice requires further attention and resolution. ‘De-tabooing’ of legal VAD will only occur with open dialogue around it (Dickens, 2008; Thulesius et al., 2013). Just as doctors are central to the VAD process in most legal systems, so should peak bodies take a central role in this conversation.

Further work is required to address the perceived incompatibility between the practices of VAD and palliative care reported in the literature and by some participants (Bélanger et al., 2019; Chambaere et al., 2011; Dyer, 2011; Gamester & Van den Eynden, 2009; Hudson et al., 2015). It is important to recognise the contributions that each discipline makes to end-of-life care. Conceiving of each practice as separate domains that can operate synergistically is one possible option (Cairns, 2019; O’Connor & Philips, 2020). This type of construction might also alleviate the fear of reduced palliative care referrals reported by some participants, and public misconceptions about the nature and objectives of palliative care.

Resource constraints within the VAD process need to be identified and managed. Participants report inadequate compensation for the additional time needed to undertake VAD assessments and manage VAD applications. Uniform, transparent funding arrangements, and ensuring that doctors have enough time to effectively transact their obligations under legal VAD systems, are necessary to ensure sustainability of access.

The theme of access barriers to VAD identified applicant, doctor, and communication constraints according to participants. A sense that strict time-based eligibility criteria might discriminate against persons without malignancy (Sleeman & Chalmers, 2019) and that a requirement for an incurable condition might be difficult to attest to in practice (Smith et al., 2013) suggests the need for permissive jurisdictions or those considering reform to ensure their VAD eligibility criteria are clear, measurable, and just. Eligibility criteria and other safeguards may need to be reconsidered to ensure regulation achieves its desired aims including patient access to VAD (White & Willmott, 2018).

In terms of the obligations placed on potential VAD providers under legal systems, it is appropriate to ensure those who participate are effectively trained
for the role they must undertake, and training needs analysis is necessary to
determine the requisite skillset. At a minimum, in addition to knowledge of the
relevant law as required in the Victorian regime, clinical skills for VAD (includ-
ing skills for practitioner administration), as well as skills in prognostication,
assessing capacity and lack of coercion, are the baseline requirements suggested
by participants for provision of VAD. Additional clarity around the legal obli-
gations of doctors who exercise their right to conscientious objection is required
to ensure appropriate continuity of care for patients (Buchbinder et al., 2016;
Cook et al., 2009; Savulescu, 2006).

The thematic finding that the willingness of doctors to participate in VAD is
situation specific suggests that strategies to address the high number of factors
which disincentivise participation are needed. There are existing proposals for
institutional frameworks to support conscientious participation in VAD
(Oliphant & Frolic, 2020). Further research into such frameworks might
supply better understanding of what ‘participation’ in VAD means (e.g. whether
mere information provision or referral constitutes participation), an under-
standing of the personal and professional factors that doctors navigate when
making participation decisions, and recognition that decision making around
VAD provision is an iterative process (Czarnecki et al., 2019).

Strengths and Limitations
This study has reported perspectives and experiences of legal VAD from those
charged with the responsibility - under most legal frameworks – to provide it.
But doctors are only one of many stakeholders in legal VAD systems – health
services, nurses, patients, families, carers, regulators, and government, all play a
role. Thorough evaluation of VAD systems must engage with all necessary
stakeholders. These perspectives would improve the rigour of the data regarding
access barriers and clinician willingness to participate.

This study has engaged doctors with no in-principle objection to legalised
VAD. It does not explore the perspectives of doctors with an ethical or moral
objection to legalised VAD. It may be that those doctors hold perspectives
about VAD systems which reveal other access issues not identified in this study.

Conclusion
While the specific circumstances of a VAD applicant might not always permit it,
in one sense, what the Victorian doctors who have participated in this study
would prescribe for legal VAD is more time. Time to do exhaustive assessments
of eligibility. Time to get to know their patient. Time to develop the clinical and
emotional skillset they need to provide VAD. Time in between VAD cases so
that they can process their role and reconcile it personally and professionally.
Yet, time is in short supply for doctors who are choosing to participate in VAD
in Victoria, owing to statutory, operational, and applicant factors. While the number of patients who accessed VAD in Victoria in the first twelve months of the law was higher than predicted, there may be a threat to its sustainability (and other systems which construct doctors as exclusive providers of VAD) as doctors’ willingness to participate in VAD decreases over time owing to disincen-
tivising factors. Efforts are needed to support more clinician participation in VAD, which is motivated by, among other things, ethical resolve, a felt obligation to provide and perceived personal benefit through being able to support patients during a critical time at the end-of-life.

Victoria remains a regulatory test case for VAD in Australia and interna-
tionally. Time must not be in short supply because it is the foundation for compassionate health care. Providing supports for doctors to take the time, both clinically and as a collective, to incorporate the newly regulated practice of VAD into the profession of medicine should become the immediate goal for government agencies and health services, to ensure individuals have genuine choices regarding their end-of-life treatment and care.

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Ethics Approval
This research was conducted under the approval of the Queensland University of Technology’s University Human Research Ethics Committee clearance number 1800000970.

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