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VOLUNTARY ASSISTED DYING: SYSTEM NEEDS REVIEW

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THE Victorian voluntary assisted dying system should be reviewed to improve its processes and its access to eligible patients, according to research published today by the *Medical Journal of Australia*.

Voluntary assisted dying became lawful in Victoria in June 2019 when the *Voluntary Assisted Dying Act 2017* (Vic) (the Act) commenced operation. To 31 December 2020, there had been 224 deaths under the Act. Other Australian states have already or are likely to legalise voluntary assisted dying in the near future.

Professors Lindy Willmott and Ben White, from the Australian Centre for Health Law Research at the Queensland University of Technology, and colleagues conducted semi-structured interviews with 32 doctors who had participated in the voluntary assisted dying system during its first year of operation.

Three major themes related to problems during the first year of operation of the Act were identified:

1. The prohibition of health professionals initiating discussions with their patients about voluntary assisted dying -- the policy aim of this prohibition was to guard against undue influence by health professionals.

"Some doctors expressed concerns this could prevent a patient making an informed choice about treatment options, particularly patients from non-English speaking backgrounds or people with poor health literacy," wrote Willmott and colleagues.

"Doctors described patients as [therefore] inevitably self-selecting. For some, this made the conversation easier."

2. The Department of Health and Human Services guidance that all doctor–patient, doctor–pharmacist, and pharmacist–patient interactions be face-to-face – this guidance reflects concerns that doctors and pharmacists might breach federal law should they use a "carriage service" (eg, telephone, email, or telehealth facilities) to discuss "suicide", even if acting lawfully under the Act.

"Many participants criticised the burden this placed on doctors, pharmacists and patients, particularly patients in rural and remote areas, a burden exacerbated during the COVID-19 epidemic," wrote Willmott and colleagues.

"Doctors spoke of the immense burden for very sick patients required to travel, sometimes for hours and several times, for eligibility assessments. Some also noted the burden on already busy doctors who travelled long distances to undertake assessments. Others saw merit in stipulating at least one face-to-face consultation."

3. Aspects of implementation, including problems with the voluntary assisted dying portal, obtaining documentary evidence to establish eligibility, and inadequate resourcing of the Statewide Pharmacy Service.

"They felt that the portal was badly designed, counterintuitive in its layout, and difficult to navigate. Concerns were also expressed about technical problems with uploading documents, with implications for busy clinicians," reported Willmott and colleagues.

"Doctors described difficulties in generating required documentation for assessing eligibility, particularly proof that a person was an Australian citizen or permanent resident, and had been ordinarily resident in Victoria for the 12 months before making a first request for voluntary assisted dying.

"Some felt this effectively locked out patients who had lived in Victoria throughout their adult lives but could not provide documentary proof of these requirements.

"Third, after a permit for voluntary assisted dying has been issued by the Department of Health and Human Services secretary, the Statewide Pharmacy Service liaises with the doctor when the required prescription is written and meets with the doctor or patient (according to what is appropriate) when the medication is delivered," they wrote.

"While participants praised the quality of their interactions with the Statewide Pharmacy Service, they generally believed that it was inadequately resourced and that this caused considerable delays."

Willmott and colleagues concluded that although safeguards ensured that systems for providing voluntary assisted dying were safe for patients and communities, "the system must also be efficient and help doctors navigate the process".

"It is therefore important to consider the perceived shortcomings reported by participating doctors. While some problems might be resolved by amending the legislative framework, others might be more readily remedied by practical support for doctors, including clear guidance about using the voluntary assisted dying portal, particularly during their initial use of the system, and adjustments in system design."

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