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Introduction

From 19 June 2019, Victorians who are at the end of their life and who meet strict eligibility criteria will be able to request access to voluntary assisted dying. This document is intended to be used by those responsible for implementing the Voluntary Assisted Dying Act 2017 (the Act) within their health service. This model of care resource aims to support the implementation of consistent care pathways across Victoria, placing the needs of a person requesting voluntary assisted dying at the centre of care while providing support for the treating healthcare team and other staff within the health service.

There are three high-level voluntary assisted dying care pathways for health services. These pathways have been informed by an extensive consultation process with a broad range of stakeholders as well as research and experience in other jurisdictions with assisted dying legislation. The care pathways may be applied across metropolitan and regional health services.

The care pathways are also supported by the Voluntary assisted dying safety and quality guidance for health services which highlights the areas, questions and resources health services may need to consider in preparing for implementation of the Act.

Resources have already been provided to health services to prepare for voluntary assisted dying and further resources will progressively be made available in the lead up to the commencement of the Act. These resources will include:

- coordination of care for people requesting voluntary assisted dying; and
- admission of people in possession of voluntary assisted dying medication.

The Department of Health and Human Services (the Department) is also developing guidance for health practitioners, training for medical practitioners and community and consumer information to support the implementation of the Act.

How to use this resource

The Department has disseminated the following preliminary information to assist health services to commence an implementation process:

- Preparing for voluntary assisted dying document - this includes a decision-making diagram, readiness checklist and sample staff survey questions for health services; and
- Voluntary Assisted Dying Act 2017 PowerPoint presentation.

These resources are available under the Health practitioners and services information tile at: https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying.

The Voluntary assisted dying model of care for health services is intended to assist health services develop and implement a care pathway for voluntary assisted dying that:

- facilitates compliance with the Act;
- is person-centred;
- facilitates consistent, safe, high-quality care for persons accessing voluntary assisted dying;
- is integrated into existing end of life care provision offered by the health service;
- provides support and guidance to health practitioners when a person under their care asks about voluntary assisted dying;
- has localised flexibility to enable health services to meet their own capacity and expertise;
• includes a pathway for those health services that choose not to or are unable to provide voluntary assisted dying.

**Service coordination**

It is recommended that each health service develops a person-centred process for managing requests for voluntary assisted dying that provides clinical support and guidance to all health practitioners within the service.

Health services must consider the level of service delivery they can safely provide for a person in their care who may request access to voluntary assisted dying. A health service’s level of participation in voluntary assisted dying will be based on a range of factors including:

• existing provision of end of life care;
• workforce capacity;
• whether there are medical practitioners and other health practitioners willing to participate;
• availability of interdisciplinary healthcare teams that are appropriately skilled in the delivery of end of life care;
• availability of support for staff who are involved in voluntary assisted dying and for those who choose not to be involved.

Health services should review the voluntary assisted dying decision-making diagram and care pathways contained in this document to determine which is the most appropriate for their health service. Once a pathway has been selected, health services can commence developing their organisational approach for voluntary assisted dying care provision.

After assessing the capacity of their service to provide voluntary assisted dying, a health service may determine they do not have the appropriate staff or service mix to provide access to voluntary assisted dying, or that providing access to voluntary assisted dying would not be consistent with the values of the health service. Even if this decision is made, consideration must still be given to the possibility that a person receiving care through the health service may request information from staff about voluntary assisted dying. All health services should be prepared to respond to requests for information about, or access to, voluntary assisted dying. Consideration must also be given to the possibility that a person may be admitted to the health service in possession of voluntary assisted dying medication.

**Health service considerations**

Considerations for the health service include:

• the level of participation in voluntary assisted dying that the health service chooses to or is able to provide (see care pathways);
• how to ensure people who request information about, or access to, voluntary assisted dying receive compassionate person-centred care and support, whichever care pathway a health service selects;
• selecting an executive sponsor to oversee voluntary assisted dying within the health service;
• the process for voluntary assisted dying referrals within the health service;
• how to integrate the Act into current health service practices, processes, protocols and systems using the Voluntary assisted dying safety and quality guidance for health services;
• workforce education about voluntary assisted dying.
Providing voluntary assisted dying within existing end of life care services

A key principle of the Act is that, where possible, existing therapeutic relationships should be maintained for a person who requests voluntary assisted dying.

Integration of voluntary assisted dying into end of life care also makes sure the person has access to all the supportive care services that are part of standard end of life care. It is expected that a person accessing voluntary assisted dying and their support persons will be linked with services that may include specialist palliative care, social work and spiritual care, psychological support and bereavement services.

Person-centred care respects and supports a person’s decisions about their own end of life care. For some, this will include voluntary assisted dying. Person-centred care will rely on health service providers continuing to provide palliative care based on clinical need. For many people requiring end of life care, a palliative care approach may be all that is required. For those requesting voluntary assisted dying, consideration must be given to whether a referral should be made to other services such as, but not limited to, a specialist palliative care service that may relieve suffering and improve quality of life.

While voluntary assisted dying cannot be requested in an advance care directive, conversations and documentation about goals of care and wishes of the person are also an important part of end of life planning discussions.

Health service considerations

Health services should consider how voluntary assisted dying is incorporated into end of life care, should the person request it. This includes:

- the process for maintaining existing therapeutic relationships where possible. When a person seeks a referral outside of their existing healthcare team, continuity of care is maintained as much as clinically appropriate, where this is desired by the person;
- voluntary assisted dying guidelines within the organisation including appropriate referral for supportive care as part of end of life care.

Workforce

Education

All health services need to educate their health practitioners on the health service’s policy and guidelines in relation to voluntary assisted dying. This education may include information such as the:

- health service’s position or policy on voluntary assisted dying;
- health service’s internal referral or decision-making process;
- health practitioner’s legal responsibility not to initiate discussion about voluntary assisted dying with a person in their care;
- details of the employee assistance program available to staff and volunteers.

The VHA and the Department will provide resources for education such as:

- slide pack presentations;
- the opportunity to attend webinar and face-to-face education sessions.
Preparedness and capacity

Under the Act, health practitioners are not required to participate in voluntary assisted dying. Therefore, health services need to assess their workforce capacity when determining their organisation’s level of participation. To make this assessment, health services may choose to conduct a staff survey or use another method of assessment to understand the preparedness of staff to be involved.

The assessment of preparedness of staff to be involved in voluntary assisted dying will help inform the care pathway selected for the health service. If the health service does not have staff who are prepared to participate, it will not be able to provide voluntary assisted dying. If the health service does have staff who are prepared to participate, it is necessary to consider their qualifications and skills, particularly those of registered medical practitioners.

Qualification and experience requirements for medical practitioners

To access voluntary assisted dying a person must be assessed by two registered medical practitioners who have specific qualifications and experience. The Act defines these practitioners as the coordinating medical practitioner and a consulting medical practitioner.

**Coordinating medical practitioner** - the coordinating medical practitioner is the registered medical practitioner who is responsible for supporting the person through the voluntary assisted dying process. This practitioner receives a person’s request, undertakes a first assessment and is responsible for reporting to the Voluntary Assisted Dying Review Board and applying to the Department for a permit for voluntary assisted dying medication.

**Consulting medical practitioner** - the consulting medical practitioner is responsible for undertaking an independent assessment of the person’s eligibility for voluntary assisted dying. This is called the consulting assessment.

Each practitioner must:

- hold a fellowship with a specialist medical college; or
- be a vocationally registered general practitioner.

Either the coordinating or the consulting medical practitioner must:

- have practised as a registered medical practitioner for at least five years after completing their fellowship or vocational registration; and
- have expertise in the person's disease, illness or medical condition (i.e. be a medical specialist in the disease, illness or medical condition).

Training

Each registered medical practitioner must complete voluntary assisted dying training before assessing a person's eligibility. This training will be available online for practitioners to complete and will take approximately four to six hours. The training may be completed in modules and at a time that is convenient for the practitioner. Practitioners are not required to undertake this training to provide information about voluntary assisted dying.

Health service considerations

As part of workforce planning, it is necessary to identify registered medical practitioners who are considering completing the appropriate training to be either a coordinating or a consulting medical practitioner for the voluntary assisted dying process.

It is also important to identify and consider other resources, including clinical and/or administrative support for successful implementation of the voluntary assisted dying model of care. By doing this, the health service will have a greater understanding of its ability to provide care for a person who makes a voluntary assisted dying request,
while also respecting the culture, beliefs and values of staff who may conscientiously object to voluntary assisted dying.

Professional obligations and supports

The introduction of voluntary assisted dying into the existing Victorian end of life framework requires health practitioners to consider changes to previous models of practice. This change may impact on an individual’s occupational stress, requiring health professionals to use established lines of professional support such as clinical supervision, debriefing and peer support networks.

Support for health practitioners, whether they choose to participate in voluntary assisted dying or conscientiously object to participating, should be developed within existing professional support structures, including working with existing health practitioner support services such as doctor health advisory services and nursing support services. This will assist in facilitating integrated and evidence-based support for health practitioners who choose to participate in voluntary assisted dying as part of their broader clinical practice.

The Act provides that a registered health practitioner who has a conscientious objection to voluntary assisted dying has the right to refuse to:

• provide information about voluntary assisted dying;
• participate in the request and assessment process;
• apply for a voluntary assisted dying permit;
• supply, prescribe or administer a voluntary assisted dying medication;
• be present at the time of administration of a voluntary assisted dying medication;
• dispense a prescription for a voluntary assisted dying medication.

Codes of conduct

All health practitioners are subject to codes of conduct and professional standards. The codes of conduct for various health practitioners provide guidance to practitioners who conscientiously object to participating in types of medical care. These include:

• **Medical practitioners** - [The Medical Board of Australia Code of Conduct](#) states that decisions about a person’s access to medical care need to be free from bias and discrimination. Good medical practice involves the medical practitioner being aware of their rights to not provide or directly participate in treatments to which they conscientiously object. It recommends informing the person and, if relevant, colleagues, of the medical practitioner’s objection, and the medical practitioner not using their objection to impede access to treatments that are legal.

• **Nurses** - [The Nursing Midwifery Board Code of Conduct](#) states that to prevent conflicts of interest from compromising care, nurses must act with integrity and in the best interests of people when making referrals, and when providing or arranging treatment or care. They must responsibly use their right to not provide, or participate directly in, treatments to which they have a conscientious objection. If a nurse has a conscientious objection, they must respectfully inform the person, their employer and other relevant colleagues, of their objection and ensure the person has alternative care options.

• **Pharmacists** - [The Pharmacy Board Code of Conduct](#) states that pharmacists have the right to not provide or participate directly in treatments to which they conscientiously object. They should inform patients or clients and, if relevant, colleagues of the objection, and should not use that objection to impede access to treatments that are legal. They should not deny patients or clients access to healthcare based on their moral
or religious views and should recognise that practitioners are free to decline to provide or participate in that care personally.

**Health service considerations**

Health services should consider:

- how to support all staff within the organisation and promote a culture of mutual respect;
- how to balance workforce planning and health practitioners’ right to conscientiously object;
- how to support staff through established lines of professional support such as clinical supervision, debriefing and peer support networks, and voluntary assisted dying specific supports such as pre-briefing and debriefing;
- how to support health practitioners, whether they choose to participate in voluntary assisted dying, choose not to participate or conscientiously object to participating;
- conducting a staff survey to assess health service employees’ interest and willingness to be involved in voluntary assisted dying.

**Building relationships**

Developing a new model of care for voluntary assisted dying will involve establishing or strengthening relationships that extend beyond current health service provider boundaries. Facilitating health services should seek to provide local, person-centred access to voluntary assisted dying to people under their care.

To establish this, it may be necessary to work with neighbouring health services that have traditionally operated in relative isolation from one another. It is important to recognise that relationship-building takes time and may require some cultural change within organisations.

**Planning and implementation**

**Adapting the model of care pathways**

Health services may adapt the care pathways in preparation for the implementation of the Act. As part of implementation planning, health services must establish whether they are willing and able to:

- participate in voluntary assisted dying and, if so, at what level; and
- facilitate access to voluntary assisted dying through another health service.

Where health services will not facilitate or provide access to voluntary assisted dying, the person can be provided with details of the voluntary assisted dying care navigator or the end of life care advisory line once established.

**Clinical testing**

Once the health service selects a care pathway that suits their context for a person wanting to access voluntary assisted dying, it is recommended that a test be conducted within the organisation to confirm that:

- appropriate resources have been adapted to support the implementation of voluntary assisted dying;
- the referral pathway within the organisation is appropriately documented;
- the pathway can be easily followed by health practitioners and other staff supporting the person who has made a request for voluntary assisted dying; and
• the person making the voluntary assisted dying request can consult with the appropriate registered medical practitioners in a timely manner.
**Voluntary assisted dying care pathways**

In preparing for voluntary assisted dying it is likely that most health services will fall into one of three high-level pathways. To assist health services to prepare, the pathways are described as follows:

- **Pathway A: Single service** - This is likely to include tertiary metropolitan health services, regional and sub-regional health services. These services are likely to have the necessary suite of services and staff with sufficient expertise to provide voluntary assisted dying within their existing health service or network.

- **Pathway B: Partnership service** - This is likely to include smaller metropolitan health services, local, small rural and multi-purpose services that currently provide care to people who are at the end of their life. These services may support and facilitate the request and assessment process but will need to establish partnerships with other health services and refer people to other services to access appropriate specialists. This may include developing partnerships with general practitioners who are willing to participate.

- **Pathway C: Information and support service** - This is likely to include health services that do not provide care to people who are at the end of their life as well as health services that have chosen not to provide voluntary assisted dying. These health services will be able to provide information and/or referrals for people who want to request voluntary assisted dying and, where appropriate, continue to provide support to these people.
Voluntary assisted dying level of participation decision-making diagram

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**Pathway C: Information and Support Service**

It is likely that your health service will not be in position to provide VAD. Prepare by
ensuring there is appropriate information and support in place. Ensure that staff:

- have access to information about VAD
- know how to respond to preliminary inquiries about VAD
- know where to direct patients to information sources
- know how to respond if a patient brings the VAD medication into the service
- are aware of options to connect patients to either:
  - medical or other health practitioners who will further assist
  - the end of life care advisory line or VAD Care Navigator

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**Pathway B: Partnership Service**

If your health service is willing to participate, identify what you can provide, how you will
manage requests and where you may need to establish partnerships with other health
services.

To prepare for the Act:

- complete the tasks in the ‘Information and Support’ box
- identify how you will respond to requests and what services you will provide
- establish procedures to ensure staff know how to respond and who is responsible for VAD documentation protocols
- identify referral pathways to ensure patients will be able to access specialist medical practitioners for eligibility assessments
- ensure appropriate staff support is available

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**Pathway A: Single Service**

If your health service is willing to participate, you will need to prepare by establishing
comprehensive policies, protocols and pathways for your health service.

To prepare for the Act:

- complete the tasks in the ‘Information and Support’ box
- identify how you will respond to requests and what services you will provide
- establish procedures to ensure staff know how to respond and who is responsible for VAD, including clear documentation protocols
- determine whether you will receive referrals for VAD and how this will occur
- ensure appropriate staff support is available
Pathway A – Single service

A person who makes a request for voluntary assisted dying is under the care of a health service that can provide voluntary assisted dying as a single service.

The health service should, as part of this care pathway, consider using or appointing staff who become familiar with and are responsible for the care coordination of a person seeking information about, or requesting access to, voluntary assisted dying. This may be part of a broader coordination role, such as a tumour stream coordinator, nurse coordinator or social worker.
Pathway B – Partnership service

A person who makes a request for voluntary assisted dying is under the care of a health service that can provide access to some of the necessary medical practitioners but needs assistance sourcing additional medical practitioners and/or specialist medical practitioner review. This may be where:

- the person’s general practitioner is willing and qualified to perform the role of the coordinating medical practitioner or consulting medical practitioner; or

- the person’s specialist is willing and qualified to perform the role of the coordinating medical practitioner or consulting medical practitioner and other medical expertise is accessed through another health service or general practitioner.

Under this pathway, the health service may use existing external partnerships and referral pathways to identify an appropriate medical practitioner. Alternatively, the voluntary assisted dying care navigator may assist in identifying an appropriate medical practitioner for referral. Health services should consider how they link with general practitioners in their area to receive referrals when a general practitioner has agreed to act as a person’s coordinating medical practitioner.
Pathway C – Information and support service

This pathway is for a health service that has chosen not to provide voluntary assisted dying or has identified that they are not able to provide voluntary assisted dying. A person who makes a request for information about, or access to, voluntary assisted dying at such a service should be provided with the necessary information about voluntary assisted dying by a health practitioner and supported to seek further information or access to voluntary assisted dying from a participating health service or medical practitioner.

A medical practitioner at the health service may also refer the person to a general practitioner or another health service that is willing and able to assist the person to access information about, or with access to, voluntary assisted dying.
Enablers for health services

Additional resources and training will support the successful implementation of the Act.

Access to information and support for health services, health practitioners and the community

Regardless of the voluntary assisted dying care pathway chosen, all health services, health practitioners, people considering voluntary assisted dying and members of the community will be able to access accurate information about end of life care, including voluntary assisted dying:

- through the end of life care advisory line;
- through a voluntary assisted dying care navigator.

The voluntary assisted dying care navigators are responsible for:

- supporting people who want to access voluntary assisted dying and their carers, family and friends;
- supporting medical and health practitioners in their roles in supporting a person accessing voluntary assisted dying; and
- assisting with supporting people who request information about, or access to, voluntary assisted dying.

Telehealth

Telehealth is an important tool to support equity of access to a range of health services for all Victorians. The use of telehealth in voluntary assisted dying must be balanced with protecting the safety of the person making a voluntary assisted dying request and providing access to the person. Where assessed as appropriate, a consulting medical practitioner assessment, or other specialist assessment (as required by either the coordinating or consulting medical practitioners) may be undertaken using telehealth. For example, telehealth may be used for:

- undertaking a consulting medical practitioner assessment;
- seeking specialist input regarding the person’s diagnosis or prognosis;
- obtaining specialist advice from a specialist physician, such as a neurologist.

Decision-making capacity and the use of telehealth

Registered medical practitioners frequently assess a person’s understanding of treatment options as part of standard clinical practice. However, when a person requests voluntary assisted dying, the medical practitioner must specifically assess the person’s capacity to make decisions about voluntary assisted dying.

Every person, inclusive of those with a mental illness or disability, is presumed to have decision-making capacity unless deemed otherwise in relation to voluntary assisted dying. Where a person’s decision-making capacity is unclear or in doubt, or the person is not known to the registered medical practitioner making the assessment, telehealth is not an appropriate tool to use. Consultation, in such situations, should occur face-to-face.

Health services should review their telehealth protocols to incorporate voluntary assisted dying practices as required. Further guidance on the use of telehealth in relation to voluntary assisted dying is being developed.
### Appropriate use of telehealth in voluntary assisted dying assessments

The table below identifies when it is appropriate to use telehealth, when it is not appropriate and when, based on the medical practitioner’s clinical judgement and expertise, it may be possible to use. Refer to the *Guidance for use of telehealth in relation to voluntary assisted dying* for further information.

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<td>Capacity clear</td>
<td>Yes, assessment can use telehealth</td>
</tr>
<tr>
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<td>Possibly</td>
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</tbody>
</table>
References


Staff Stress, Work Satisfaction, and Death Attitudes on an Oncology Palliative Care Unit, and on a Medical and Radiation Oncology Inpatient Unit. Pierce, Bruce; Dougherty, Elizabeth; Panzarella, Tony; Le, Lisa W; et al. Journal of Palliative Care; Montreal Vol. 23, Is. 1, (Spring 2007): 32-9

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