Development of Voluntary Assisted Dying Training in Victoria, Australia: A Model for Consideration

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

Ben P White, DPhil, LLB(Hons),[1] Lindy Willmott, PhD, LLM, LLB(Hons), BCom,[2] Eliana Close, PhD, MA, BSc(Hons),[3] Jayne Hewitt, PhD, LLM, LLB, BN,[4] Rebecca Meehan, LLB(Hons), BHlthSc(Pod),[5] Laura Ley Greaves, MBBS, BSc(Hons),[6] Malcolm H Parker, MD, MHealthMedLaw, MLitt(Hons1), MBBS,[7] Patsy Yates, PhD, MSocSc, BA, DipAppSc.[8]

Author Disclosure Statement

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

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

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

[1] Australian Centre for Health Law Research, Faculty of Law, Queensland University of Technology, Brisbane, Queensland, Australia.
[2] Australian Centre for Health Law Research, Faculty of Law, Queensland University of Technology, Brisbane, Queensland, Australia.
[3] Australian Centre for Health Law Research, Faculty of Law, Queensland University of Technology, Brisbane, Queensland, Australia.
[4] Australian Centre for Health Law Research, Faculty of Law, Queensland University of Technology, Brisbane, Queensland, Australia.
[5] Australian Centre for Health Law Research, Faculty of Law, Queensland University of Technology, Brisbane, Queensland, Australia.
[6] Australian Centre for Health Law Research, Faculty of Law, Queensland University of Technology, Brisbane, Queensland, Australia.
[7] Faculty of Medicine, University of Queensland, Brisbane, Australia.
[8] Faculty of Health, Queensland University of Technology, Brisbane, Queensland, Australia.

Corresponding Author:
Ben White, Faculty of Law, Queensland University of Technology, Gardens Point, 2 George Street, Brisbane, Queensland, 4000, Australia.
Email: bp.white@qut.edu.au

Abstract

Background

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

Objective

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

Design

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

Results

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

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

Conclusion

The Victorian legislatively-mandated voluntary assisted dying training provides standardised baseline knowledge to enhance the quality and consistency of decision-making by doctors. While further evaluation of this training is needed, it may provide a model for other jurisdictions considering making voluntary assisted dying lawful.

Key words

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

Introduction

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

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

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

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

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

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

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

Design process

Establishment

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

Principles informing design

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

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

Developing training content

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

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

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

Focus group testing

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

Content, delivery and operation

Content

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

Table 1: Voluntary Assisted Dying (VAD) Training Modules

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

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

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

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

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

Face to face training

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

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

Assessment

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

Evaluation

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

Implications of the Victorian model of training

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

State-endorsed VAD training

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

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

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

VAD training's role as a safeguard

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

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

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

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

Training prior to VAD becoming lawful

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

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

Conclusion

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

References

1. *Voluntary Assisted Dying Act 2017* (Vic) s 9.
2. Victoria State Government [Internet]. Victoria: State of Victoria; c2019. Media Release, Voluntary assisted dying model established ahead of vote in parliament; 2017 Jul 25 [cited 2019 Dec 9]; [1 p.]. Available from: https://www.premier.vic.gov.au/voluntary-assisted-dying-model-established-ahead-of-vote-in-parliament/.
3. White BP, Willmott L, Close E. Victoria's voluntary assisted dying law: clinical implementation as the next challenge. Med J Aust. 2019 Mar;10(5):207-209.
4. *Voluntary Assisted Dying Act 2017* (Vic) ss 17, 26.

5. Ministerial Advisory Panel on Voluntary Assisted Dying. Final Report. Victoria: Department of Health and Human Services; 2017 Jul. p 104.
6. Ministerial Advisory Panel on Voluntary Assisted Dying. Final Report. Victoria: Department of Health and Human Services; 2017 Jul. p 106.
7. Fujioka JK, Mirza RM, Klinger CA, McDonald LP. Medical assistance in dying: implications for health systems from a scoping review of the literature. J Health Serv Res Policy. 2019 Jul;24(3):207-216.
8. Ball IM, Hodge B, Jansen S, Nickle S, Sibbald RW. A Canadian academic hospital's Initial MAID experience: a health-care systems review. J Palliat Care. 2019 Apr;34(2):78-84.
9. Hogg S, Nippak P, Spalding K. Implementation of medical assistance in dying: an evaluation of clinician knowledge and perceptions at a large urban multi-site rehabilitation centre in Toronto. J Hosp Adm. 2018 Oct;7(5):41-49.
10. Munday T, Poon P. Geriatricians' attitudes towards voluntary assisted dying; a survey of Australian and New Zealand Society for Geriatric Medicine members. Australas J Ageing [Internet]. 2019 Jun 28 [updated 2019 May 5;cited 2019 Dec 9]:1-9. Available from: https://doi.org/10.1111/ajag.12681.
11. Karapetis CS, Stein B, Koczwara B, et al. Medical Oncology Group of Australia position statement and membership survey on voluntary assisted dying. Intern Med J. 2018 Jul;48(7):774-779.
12. Downar J, Green S, Radhakrishnan A, et al. An entrustable professional activity descriptor for medical aid in dying: a mixed-methods study. CMAJ Open. 2018 Oct-Dec;6(4):E657-E663.

13. Ding JZ, Casey G, Kekewich M, Wiesenfeld L, Naik VN. Medical assistance in dying: a structured postgraduate elective to build confidence in caring for patients. Can J Anaesth. 2019 Sep 15;66(9):1121-1122.
14. Hesselink BAM, Onwuteaka-Philipsen BD, Janssen AJGM, et al. Do guidelines on euthanasia and physician-assisted suicide in Dutch hospitals and nursing homes reflect the law? A content analysis. Journal of Medical Ethics. 2012 Jan 27;38(1):35-42.
15. Loggers ET, Starks H, Shannon-Dudley M, Back AL, Appelbaum FR, Stewart FM. Implementing a Death with Dignity program at a comprehensive cancer center. N Engl J Med 2013 Apr 11;368(15):1417-1424.
16. Van Wesemael Y, Cohen J, Onwuteaka-Philipsen BD, Bilsen J, Deliens L. Establishing specialized health services for professional consultation in euthanasia: experiences in the Netherlands and Belgium. BMC Health Serv Res [Internet]. 2009 Dec 4 [cited 2019 Dec 9];9:Article 220 [7 p.]. Available from: https://doi.org/10.1186/1472-6963-9-220.
17. Van Wesemael Y, Cohen J, Bilsen J, et al. Implementation of a service for physicians' consultation and information in euthanasia requests in Belgium. Health Policy. 2012 Mar;104(3):272-278.
18. Cohen J, Van Wesemael Y, Smets T, et al. Nationwide survey to evaluate the decision-making process in euthanasia requests in Belgium: do specifically trained 2nd physicians improve quality of consultation? BMC Health Serv Res [Internet]. 2014 Jul 16 [cited 2019 Dec 9];14:Article 307 [9 p.]. Available from: https://doi.org/10.1186/1472-6963-14-307.

19. University Health Network Toronto [Internet]. Toronto: University Health Network; c2019. Medical Assistance in Dying; 2019 [cited 2019 Dec 9]. Available from: www.uhn.ca/healthcareprofessionals/MAID.
20. *Voluntary Assisted Dying Act 2017* (Vic) ss 17, 26, 114.
21. Fujioka JK, Mirza RM, McDonald PL, Klinger CA. Implementation of Medical Assistance in Dying: a scoping review of health care providers' perspectives. *J Pain Symptom Manage*. 2018 Jun;55(6):1564-1576.
22. Buchbinder M, Brassfield ER, Mishra M. Health care providers' experiences with implementing Medical Aid-in-Dying in Vermont: a qualitative study. J Gen Intern Med. 2019 Apr 15;34(4):636-641.
23. White B, Willmott L, Cartwright C, Parker MH, Williams G. Doctors' knowledge of the law on withholding and withdrawing life-sustaining medical treatment. Med J Aust. 2014 Aug;201(4):229-232.
24. Cartwright CM, White BP, Willmott L, Williams G, Parker MH. Palliative care and other physicians' knowledge, attitudes and practice relating to the law on withholding/withdrawing life-sustaining treatment: survey results. Palliat Med. 2016 Feb;30(2):171-179.
25. White B, Willmott L, Cartwright C, Parker MH, Williams G. Knowledge of the law about withholding or withdrawing life-sustaining treatment by intensivists and other specialists. Crit Care Resusc. 2016 Jun;18(2):109-115.
26. Li M, Watt S, Escaf M, et al. Medical assistance in dying—implementing a hospital-based program in Canada. N Engl J Med. 2017 May 25;376(21):2082–2088.