Exploring the drivers of expedited pathways in voluntary assisted dying

Summary of Practitioner Consultation Findings

Background

Under the *Voluntary Assisted Dying Act 2019* (the Act), a patient may make their final request within the designated period (nine days between the First request and Final request) only where both the Coordinating Practitioner and Consulting Practitioner agree that the patient is likely to die or lose decision-making capacity before the end of the period.

The Voluntary Assisted Dying Board (the Board) has observed an increase in the number and proportion of patients making their Final Request for voluntary assisted dying (VAD) within the designated period, indicating that a growing number of patients appear to be seeking access to VAD late in the course of their illness.

The Board understands that this may place additional demands on patients, families, practitioners and the broader VAD system, as all legislative and clinical process requirements must be completed within a compressed timeframe.

The Board is seeking to better understand the factors contributing to patients accessing VAD via an expedited pathway to support its statutory function of monitoring the operation of the Act and identifying opportunities for quality improvement.

Approach

The Board facilitated a structured workshop during the Statewide Care Navigator Service (SWCNS) VAD Practitioner Forum to explore the factors contributing to patients accessing VAD via an expedited pathway.

Participants comprised health professionals involved in the delivery of VAD services, including VAD trained medical and nurse practitioners, pharmacists, care navigators and VAD coordinators.

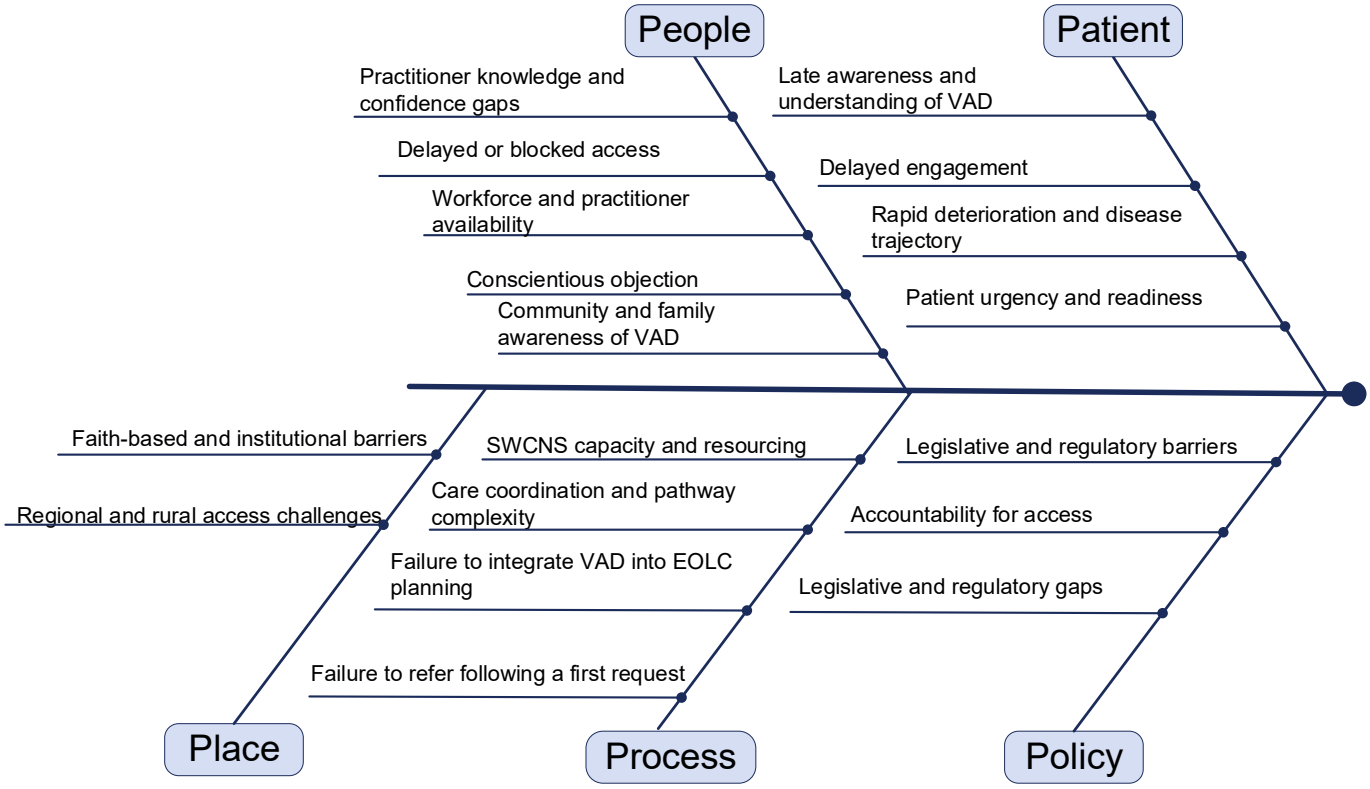
Using a facilitated driver diagram exercise, participants worked in small groups to identify and discuss factors that may contribute to expedited pathway access. Responses were recorded on fishbone diagram templates and grouped under five predefined domains: People, Place, Process, Policy and Patient. Participants were encouraged to use a root-cause analysis approach by repeatedly asking “why” to move beyond immediate causes and identify underlying drivers.

Workshop outputs were subsequently collated and coded into common themes to support qualitative analysis and identification of key drivers influencing expedited pathway access.

Findings summary

Analysis of workshop outputs identified a range of interrelated patient, practitioner, organisational, process and policy factors contributing to patients accessing VAD via an expedited pathway. Participant responses (n=110) were coded into seventeen drivers across the five domains of Patient, People, Place, Process and Policy, as outlined in Figure 1.

Figure 1. Drivers of access to voluntary assisted dying via an expedited pathway



The factors most frequently identified by participants were People (n=34) and Patient (n=34). Awareness and knowledge gaps emerged as the most prominent theme across the workshop findings, with 28 responses coded to this theme. Participants identified a range of factors relating to patient awareness of VAD (n=9), practitioner knowledge and confidence (n=12), and broader family and community awareness of VAD as an end-of-life care option (n=7).

A consistent finding across all domains was that many of the identified factors occur early in the patient journey, before a patient reaches the point of commencing the VAD process by making a First Request. Participants highlighted opportunities to improve awareness, communication, end-of-life care planning, referral processes and access to practitioners. Collectively, these findings suggest that interventions aimed at earlier engagement may reduce the need for patients to access VAD via an expedited pathway.

Domain analysis

Within the Patient domain, participants frequently identified factors associated with awareness, engagement and clinical deterioration. Common themes included limited awareness and understanding of VAD, delayed engagement with the VAD process due to personal, family or social factors, and patient concerns about future suffering, loss of capacity and loss of choice. Participants also highlighted the role of rapid deterioration, changing disease trajectories and prognostic uncertainty, which can significantly reduce the time available for patients to complete the standard VAD pathway.

Within the People domain, participants identified several factors relating to practitioner knowledge, behaviours and workforce capacity. Participants described instances where practitioners had limited knowledge of VAD processes, timelines or legal obligations, resulting in delays or missed opportunities for discussion. Concerns were also raised regarding delayed, ignored or blocked access, particularly where patient requests were not recognised or appropriately actioned. Workforce shortages, particularly in regional areas, and the impact of conscientious objection on patient progression through the VAD pathway were also identified as contributing factors.

Within the Place domain, participants highlighted the influence of the healthcare setting and geographic location on VAD access. Faith-based and institutional restrictions were raised as potential barriers to timely access, particularly where organisational policies limited the provision of VAD-related information, referrals or services. Participants also identified regional and rural challenges, including workforce shortages, geographic distance, travel requirements and variability in service availability across the State.

Within the Process domain, participants identified opportunities to strengthen how VAD is incorporated into broader end-of-life care planning and service delivery. Common themes included VAD not being routinely discussed alongside palliative care, prognosis or treatment planning conversations, delayed or absent referrals following a first request, and complexity associated with navigating the VAD pathway. Participants also highlighted increasing demand on care navigation services, resourcing pressures and administrative processes that may contribute to delays.

Within the Policy domain, participants identified legislative, regulatory and governance factors that may influence access to VAD. These included legislative and regulatory requirements affecting service delivery, perceived gaps in existing frameworks, and concerns regarding accountability for ensuring timely access to VAD services. Participants also highlighted the absence of clear service expectations or performance measures relating to equitable access across health services and care settings.

A detailed tree driver diagram, including assigned definitions and summary of participant comments against each driver can be found in Appendix 1.

Potential quality improvement opportunities

While the workshop was primarily designed to identify drivers of expedited pathway access, participants were also invited to consider potential actions that may address the issues identified.

The opportunities outlined below are based on themes emerging from participant feedback and suggested improvements explicitly identified by participants during the exercise.

- Improve awareness and understanding of VAD: Increase patient, family, community and health practitioner awareness of VAD, eligibility requirements and access pathways to support earlier engagement with the process.
- Support earlier end-of-life care planning: Encourage earlier discussions regarding prognosis, advance care planning, palliative care and VAD as part of routine end-of-life care conversations.
- Strengthen practitioner capability and workforce capacity: Enhance practitioner education, peer support and workforce development initiatives to improve confidence, knowledge, participation and access, particularly in regional areas.
- Improve referral pathways: Strengthen referral pathways following a first request and improve patient access to care navigation and coordination services.
- Review legislative, regulatory and governance barriers: Consider opportunities to address legislative, regulatory and governance issues identified by participants that may affect timely and equitable access to VAD.

Next steps

This report will be provided to the Voluntary Assisted Dying Board to inform its understanding of the operation of the Act. The findings will support the Board in performing its function of monitoring and advising on the operation of voluntary assisted dying in accordance with the principles of the Act.

Appendix 1: Driver tree diagram

PATIENT FACTORS (n=34)

Late Awareness and Understanding of VAD (n=9)

Patients, families or the broader community have limited awareness or understanding of VAD, eligibility requirements, available supports, or the time required to complete the process.

Summary of participant comments:

- Limited awareness of VAD as an end-of-life care option.
- Lack of patient, family and community education regarding VAD.
- Limited understanding of the VAD process and associated timeframes.
- Patients may not recognise that they are actively dying.
- Uncertainty about how to access VAD services, particularly where support is limited.
- Limited availability of targeted information and community awareness initiatives.

Delayed Engagement with VAD (n=8)

Patients delay initiating or engaging with the VAD process due to personal, family or social factors, despite potential awareness of VAD as an option.

Summary of participant comments:

- Patients delay making a first request despite awareness of VAD.
- Reluctance to discuss VAD due to fear, stigma or denial.
- Family influences may delay engagement with the VAD process.
- Patients may struggle to advocate for themselves or raise VAD with treating practitioners.
- Ongoing pursuit of treatment options may delay consideration of VAD.

Patient Urgency and Readiness (n=9)

Patients wish to progress through the VAD process quickly due to concerns about future suffering, loss of capacity, loss of choice or changing personal circumstances.

Summary of participant comments:

- Concerns about future suffering.
- Fear of losing decision-making capacity.
- Perceived need to progress quickly once a decision has been made.
- Concerns about missing the opportunity to access VAD.
- Changes in goals of care or family circumstances creating urgency.

Rapid Deterioration and Disease Trajectory (n=8)

Changes in a patient's condition, prognosis or rate of decline reduce the time available to complete the standard VAD pathway.

Summary of participant comments:

- Rapid or unexpected clinical deterioration.
- Advanced disease at the time of first engagement with VAD.

- Changes in prognosis or disease trajectory during the VAD process.
- Uncertain prognosis resulting in late identification of deterioration.
- Unplanned hospital admissions and late presentation.

PEOPLE FACTORS (n=34)

Practitioner Knowledge and Confidence Gaps (n=12)

Health practitioners have limited knowledge, confidence or understanding of VAD processes, legal obligations, eligibility requirements or referral pathways.

Summary of participant comments:

- Limited understanding of VAD processes and timelines.
- Lack of awareness of legal obligations and practitioner responsibilities.
- Variation in interpretation of legislation and eligibility requirements.
- Reluctance or failure to discuss VAD as a care option.
- Difficulty discussing prognosis, dying and end-of-life planning.
- Inconsistent knowledge across practitioners due to high staff turnover, particularly in regional settings.

Delayed, Ignored or Blocked Access (n=6)

Patient requests or referrals are delayed, not recognised, not actioned, or encounter barriers that impede timely access to VAD services.

Summary of participant comments:

- First requests not recognised, acknowledged or acted on.
- Delayed referrals to participating practitioners or services.
- Patients receiving incorrect information.
- VAD requests being ignored or declined without appropriate referral.
- Treating teams inadvertently or deliberately creating barriers to access.

Workforce and Practitioner Availability (n=5)

Limited availability, capacity or distribution of participating practitioners affects timely patient access to VAD assessments and services.

Summary of participant comments:

- Limited availability of participating practitioners.
- Rural workforce shortages.
- Barriers to becoming a participating practitioner.

Community and Family Awareness of VAD (n=7)

Limited awareness and understanding of VAD within the broader community, families and support networks may delay discussions and engagement with the VAD process.

Summary of participant comments:

- Community awareness.
- Death taboo.
- Family awareness and education.
- Lack of public information and advertising.

Conscientious Objection (n=4)

Practitioner behaviour is influenced by personal beliefs regarding VAD, which may affect how requests are responded to, referred or progressed through the VAD pathway.

Summary of participant comments:

- Practitioner conscientious objection creating delays in access.
- Personal beliefs influencing responses to patient requests.
- Failure to appropriately support referral pathways following objection.

PLACE FACTORS (n=12)

Faith-Based and Institutional Barriers (n=6)

Organisational policies or institutional positions limit or influence patient access to VAD information, referrals or services.

Summary of participant comments:

- Restrictions within faith-based health services and aged care settings.
- Institutional objections affecting patient access.
- Transfer from faith-based institution resulting in delays.

Regional and Rural Access Challenges (n=6)

Geographic location, service distribution and travel requirements create additional barriers to accessing VAD services and participating practitioners.

Summary of participant comments:

- Geographic isolation, travel requirements and logistical challenges.
- Limited access to local practitioners and services.
- Regional service boundary issues.

PROCESS FACTORS (n=15)

Failure to Integrate VAD into End-of-Life Care Planning (n=5)

VAD is not routinely incorporated into prognosis discussions, advance care planning, treatment decision-making or broader end-of-life care conversations.

Summary of participant comments:

- VAD not routinely discussed alongside palliative care and active treatment options.
- Advance care planning discussions occurring too late.
- Prognosis and dying not discussed early enough.
- Missed opportunities to introduce VAD as part of treatment decision-making.

Failure to Refer Following a First Request (n=3)

Lack of understanding of need to refer, or failure to take or action, following a refused First Request.

Summary of participant comments:

- Lack of action following a refused First Request.
- First requests not resulting in referral or progression through the pathway.
- Delays between first request and connection to participating practitioners.

Care Coordination and Pathway Complexity (n=2)

Multiple interactions and administrative requirements create challenges for patients and practitioners navigating the VAD pathway

Summary of participant comments:

- Multiple appointments and meetings required.
- Triage and intake processes creating additional steps.

SWCNS Capacity and Resourcing Pressures (n=5)

Demand for Statewide Care Navigator Service support exceeds available capacity, resulting in delays or constraints within the VAD pathway.

Summary of participant comments:

- Increasing demand for care navigation services.
- Delays in intake and allocation processes.
- Resource constraints affecting responsiveness.
- Care navigation bottlenecks contributing to downstream pressure.

POLICY FACTORS (n=15)

Legislative and Regulatory Barriers (n=8)

Legislative, regulatory or administrative requirements directly affect the timing, availability or accessibility of VAD services.

Summary of participant comments:

- Telehealth and Commonwealth carriage service restrictions.
- Restrictions on which professionals may discuss VAD.
- Residency, visa and eligibility requirements.
- Uncertain prognostic timeframes affecting patient access.

Legislative or Regulatory Gaps (n=4)

Areas where legislation, regulation or governance arrangements are perceived to inadequately support consistent, timely or equitable access to VAD.

Summary of participant comments:

- Perceived gaps in the management of conscientious objection.
- Lack of mechanisms to address obstruction of access.
- Concerns regarding accountability when access is delayed.

Lack of Accountability for Access (n=3)

There is no clear responsibility, performance expectation or governance mechanism to ensure timely and equitable access to VAD services.

Summary of participant comments:

- No clear responsibility for ensuring timely access.
- Absence of minimum service expectations or system-wide performance measures relating to access.
- Limited accountability mechanisms for health service provision.