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Support for and willingness to be involved in voluntary assisted dying: a multisite, cross-sectional survey study of clinicians in Victoria, Australia

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**Title:** Support for and willingness to be involved in voluntary assisted dying: A multisite, cross-sectional survey study of clinicians in Victoria, Australia

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## Introduction

The Voluntary Assisted Dying Act (Vic) was passed by the Victorian parliament in November 2017 and came into effect on June 19 2019.(1) The Act allows Victorians who meet eligibility criteria to request a doctor prescribe a lethal substance to self-ingest or, in limited circumstances, directly administer a lethal substance to the patient (see Box 1 for key features and definitions)(2). Broadly, any clinician may receive an initial enquiry or request for VAD, however, patient access is dependent on assessment by a minimum two doctors (vocationally registered general practitioners or medical specialists) who have undertaken additional VAD training,(3) one of whom must have expertise in the patient's terminal disease. Hence, a potential challenge for the implementation of VAD is the ability to identify qualified and trained doctors to complete the request and assessment process.(4)

International studies consistently show levels of physician support for the practice of VAD to be lower than the general public,(5-8). In addition, only a minority of doctors are willing to be involved in VAD, even if they hold 'in-principle' support for its legalization.(9) However, Australian clinician data prior to the passage of the Victorian VAD legislation context were scarce. In 2017, a survey conducted at a single Victorian institution showed that clinicians were divided on whether they supported VAD (28% support vs. 28% opposed), with 44% being uncertain.(10) Similarly, a 2018 survey by the Medical Oncology Group of Australia similarly identified that 46% of members disagreed with VAD, 36% agreed and 17% were neutral on VAD.(11) The authors from both studies acknowledge their limited small sample sizes. There is currently a lack of research examining reasons underlying doctors' willingness to participate (or not) in VAD.(12)

Understanding clinician attitudes to VAD, and underlying factors influencing support for and willingness to be involved in VAD, will assist healthcare institutions implementing VAD to develop context specific policies, procedures and resources better tailored to staff's needs. Moreover, given Victoria's requirement that one of the assessing doctors be an expert in a requesting patient's terminal disease,(13) baseline information regarding support for VAD among specialists working in fields likely to receive VAD requests,(14, 15) such as oncology and neurology, is a critical consideration for any institution contemplating providing VAD to their patients.

To address this gap in the literature, and to assist services with the implementation of VAD, in the months prior to VAD becoming legal in Victoria we undertook a multisite, cross-sectional survey of clinicians in seven Victorian hospitals to describe both support for and willingness to be involved in VAD once legal. A secondary aim was to consider factors that may be associated with clinician support for the VAD legislation and physicians' willingness to provide VAD in practice.

## Method

Study reporting is based on the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) Statement: guidelines for reporting observational studies.(16)

Between November 2018 and February 2019, an anonymous cross-sectional online survey was conducted across seven Victorian public healthcare institutions with the approval of the Austin Health Human Research Ethics Committee (reference number HREC/45754/Austin/2018), and site-specific approvals. Therefore, the survey was conducted after the VAD legislation had been passed (November 2017) but prior to becoming legal practice in the state (June 2019).

### *Survey development*

The survey included educational information about the Act and contained four sections (Supplemental File S1), with the number and nature of the questions dependent on the participant's clinical role. Questions were developed through expert discussion within the research team following a literature review, and were piloted and refined after testing with clinicians, resulting in some minor language changes to improve clarity of the questions being asked. Questions included participant demographics and awareness and support for Victoria's legalization of VAD, willingness to participate in VAD related activities and reasons for willingness to participate in VAD activities. A separate study that examined the anticipated challenges of the VAD legislation has already been published.(2)

### *Sampling*

We surveyed six (out of ten similar) major metropolitan adult and non-Catholic hospitals and a non-metropolitan rural service likely to receive VAD requests.(17) Clinical staff who worked across seven Victorian public healthcare institutions (five metropolitan tertiary referral services, one large metropolitan specialist service, and one regional service) were invited to

complete the survey using clinician email lists and through advertisements on staff intranet websites. Surveys were sent to clinicians working on both acute and sub-acute hospital wards. Participants were eligible if they were aged 18 years or older and worked as clinical staff at the time of the study. Participation was voluntary and all responses were anonymous. Participants were informed that consent was implied by completing the survey. The survey took approximately 15-30 minutes to complete.

Given the use of non-probabilistic sampling (i.e. opt-in), we were unable to estimate a response rate in accordance with standardized definitions.(18) Participants were included in the final sample if they had completed sufficient questions to address the research questions (up to the question asking about support for Victoria's VAD legislation). In addition, each site-level database was monitored for evidence of duplication of complete responses and ineligible participants (non-clinical staff) were removed.

*Data analysis*

Stata version 15.1 (StataCorp, USA) was used to conduct variable re-coding and descriptive statistical analyses. Univariate associations for categorical variables were considered using either chi-square or Fisher's exact test. Multivariate logistic regression analysis was conducted to identify factors independently associated with support for VAD. Multivariable analysis also considered associations between medical specialist's willingness to be either a consulting or coordinating practitioner and demographic characteristics and/or reasons for support for VAD. The reasons were classified as 'important' if they were indicated as either 'very important' or 'of the utmost importance' in the response to the survey. Each reason was considered separately with Odds Ratios estimated to quantify the strength of the association, given the high degree of correlation between several groups of reasons included in the survey (e.g. correlation of 0.77 between religion/spirituality and cultural beliefs).

High-impact specialties (those considered likely to receive the majority of requests for VAD based on international experiences *and* which fulfil the Act's specialist expertise requirements) were defined as oncology, haematology, neurology, cardiology and respiratory medicine.(14, 15) Whilst specialists from palliative care and geriatric medicine were also likely to be highly impacted by VAD, we considered these two specialties as a separate high-impact specialty group. This was because despite these groups being highly likely to receive VAD

requests and are able to be an assessing doctor, they do not fulfil the Act's specialist requirements.(13)

## Results

Of the 5690 individuals who opened the survey, 475 did not complete the question asking about their support for VAD and an additional 66 were non-clinicians. Thus 5159 participants were included in the final sample.

The characteristics of the sample and support for Victoria's VAD legislation are shown in Table 1. Nineteen percent (119/619) of medical specialists worked within a high-impact specialty, and 13% (78/619) specialized in geriatrics or palliative care, while 21% (132/619) reported treating patients with incurable illness daily (see Supplementary Table 1 for characteristics of medical specialists and support for VAD legalisation).

Overall, most participants were aware of (92%) and indicated support for the Victorian VAD legislation (73%, see Table 1). Support levels were similar across the seven sites and ranged from 67% to 83%. Nurses were more likely than not to express support for VAD (2240 supportive, 604 not supportive) but medical specialists were more evenly divided, and as likely as not to express support for VAD (314 supportive, 305 not supportive).

### *Correlates of support for VAD*

To identify which factors were independently associated with support for VAD among all participants (n=5159), a multivariable logistic regression analysis was performed (Table 2). The strongest predictor of support for VAD was clinical role. Nurses and allied health staff had significantly greater odds of supporting the VAD legislation compared to medical specialists. Support was also significantly associated with self-reported knowledge of the legislation, with the highest levels of support among those with limited knowledge, the lowest levels among those unaware of the legislation, and those with extensive knowledge in between.

Similarly, to identify which factors were independently associated with support for VAD among medical specialists, a second multivariable logistic regression analysis was performed (Table 2). Those who had been specialists for >20 years were twice as likely to support VAD compared to those who had been specialists <10 years. In addition, doctors working in high-impact specialties were significantly less likely to support legalization of VAD compared to

doctors working in low-impact specialties. This observation was even more marked among palliative care physicians and geriatricians.

*Willingness to participate in activities associated with VAD*

Clinical staff were asked about their willingness to provide usual care for a patient who had requested VAD. Separately they were asked about their willingness to participate in VAD specific activities. Each clinical group answered versions of these questions tailored to their roles (see Table 3). Roughly 90% of both junior doctors and nurses reported being willing to provide usual care to a patient who had requested VAD, with a lower percentage (77%) of senior medical staff also reporting willingness to do so. In relation to clinical activities directly related to VAD, nurses appeared to be most willing to participate with a majority being willing to put in an IV cannula for the VAD injection (64%) or be present at a VAD death (75%) compared to a minority of medical specialists who were willing to either put in an IV cannula for VAD injection (21%) or be present at a VAD death (36%).

*Correlates of willingness to act in coordinating or consulting physician roles*

Taken together, 40% (n=238) of medical specialists indicated they would be willing to participate in at least one of the three activities associated with the either the consulting or the coordinating role (items 1.2 to 1.4, table 3). There was no difference in willingness to participate in at least one of the activities associated with either the consulting or the coordinating role between high impact (44%, n=52) and low impact specialty staff (41%, n=173), but doctors specializing in palliative care or geriatric medicine were significantly less willing to participate (27%) (see Supplementary Table 2), when compared to low impact specialty staff, which was confirmed upon multivariable analysis (p=0.010). The multivariable model also found that medical specialists aged 31-40 and 60+ were significantly more willing to participate in either the consulting or the coordinating role (31-40: p=0.022 and 60+: p=0.032, respectively), when compared to the reference group 41-50 years. There were no other statistically significant associations between willingness and medical specialist's demographic characteristics, including site, gender and years in role.

As expected, medical specialists supporting the VAD legislation were more willing to participate in either the consulting or the coordinating role (62%) compared to those not supporting the VAD legislation (11%), which was confirmed upon multivariable analysis

($p<0.001$), after adjusting for site, gender, age, high impact specialty and years of experience. In addition, associations between the importance of 16 potential reasons underlying medical specialist's willingness or unwillingness to participate in either the consulting or coordinating role and medical specialist's willingness (yes, no) to participate in either role was included in 16 separate multivariable models (see Table 4). The strongest predictors of medical specialist's willingness to participate in VAD were reasons 2 (respecting a patient's right to request VAD), 3 (allowing patient to choose time of death) and 1 (giving patients access to a legally sanctioned medical intervention), with medical specialists who listed any of these reasons as important being more than 5 times as likely to be willing to act as either a consulting or coordinating physician for a patient requesting VAD.

In contrast, reasons 7 (your religion/spirituality), 6 (your cultural beliefs), 5 (your personal beliefs) and reason 11 (your perceived emotional burden on you) were identified as the strongest predictors of medical specialist's unwillingness to participate in either consulting or coordinating of VAD. The Odds Ratio of 0.21 for Religion/Spirituality is indicative of respondents who are almost 5 times less likely to participate in consulting or coordinating of VAD if identified as a very or of utmost important reason.

**Discussion**

Although most clinical staff (73%) surveyed supported the introduction of VAD in Victoria, the odds of nurses and allied health staff being in support of the legislation was significantly greater when compared to medical specialists. In addition, a minority (44%) of medical specialists from high-impact specialties and of medical specialists overall (40%) were willing to participate in at least one of the activities associated with either the consulting or coordinating VAD role(s). These findings indicated potential access issues for Victorian patients if demand for timely assessment were to exceed the capacity of the health system to respond to that demand. The results also indicate a need for health services to engage with and provide additional support to the staff most likely to be involved with or treat patients likely to request VAD.

Consistent with past international studies,(19, 20) we found that nurses (79%) and allied health staff (78%) were significantly more likely to support VAD compared to medical specialists (51%). Moreover, the low absolute number (44%, n=52) of doctors from high impact

specialties who were willing to participate in VAD is similar to recent data released by the Victorian Government, which shows that only 157 doctors have been involved in one or more VAD cases in the 18-months since becoming legal, of which just 58 reported as specializing in a high-impact specialty, as per the definition used in this study.(21) This also corresponds with data from other jurisdictions internationally, such as in Oregon, where it is estimated that just 1% of actively licensed physicians provide VAD.(5, 22)

We also found that doctors practising in palliative or geriatric medicine were significantly less likely to support the VAD legislation or be willing to participate in VAD activities compared colleagues from other high-impact specialties. This finding is broadly consistent with other past survey studies(6, 23-25) and may suggest that philosophical values associated with certain professional roles or disciplines may influence a clinician's view on VAD. For example, a recent qualitative study undertaken in Victoria showed that some palliative care specialists believe VAD is fundamentally different to the core principles of palliative medicine, with some reporting the palliative care wards in their service had refused to provide VAD since becoming legal.(26) Moreover, our findings are consistent with the formal positions taken by the same Australian professional bodies, where lower levels of support were observed in statements from bodies representing doctors(27, 28) or palliative(29) and geriatric(30) medicine compared to bodies representing nurses.(31)

Irrespective of specialty, however, we found the most significant factors underlying medical specialists' decision to participate in VAD were the reasons 'respecting a patient's right to request VAD', 'allowing a patient to choose time of death', 'giving patients access to a legally sanctioned medical intervention' and 'relieving patient suffering'. Although few studies have similarly examined the reasons underlying doctor's willingness to participate in VAD,(9) these findings appear to align with a dominant policy goal underpinning the Act: to respect personal autonomy.(32) Arguably another dominant principle underpinning the Victorian legislation is to ensure individual and community safety, reflected in VAD access restricted to those meeting strict eligibility. The survey did not specifically enquire about safeguards but few medical specialists reported safety related issues as reasons for being unwilling to participate in VAD, in an open-ended 'other reasons' section of the survey. Whilst the reasons for this were unclear, one potential reason reflect the greater emphasis on safety in the Act compared to other jurisdictions internationally.(33, 34)

This study has some limitations to consider. Firstly, it was a cross-sectional survey capturing clinicians' support for and willingness to be involved in VAD, in anticipation of VAD legislation coming into effect (data was collected after the legislation passed, though prior to becoming legal). Thus, we are unable to determine whether clinician's support and willingness levels changed once VAD was introduced in practice. In addition, while the study was the largest known of its type in terms of sample size, given our opt-in sampling methodology, the generalizability of the findings to other health services may be limited and may be biased towards respondents with either strong support or opposition to the VAD legislation. Moreover, a majority of respondents were younger (aged $\leq$40 years) and non-metropolitan services could be underrepresented given only one non-metropolitan service participated in the survey. However, this study was largely descriptive, and future research may attempt to replicate the findings over time for comparison and employ other methodologies to achieve population representative samples. Furthermore, this study focusses on clinician views on Victoria's VAD legalization, and results may not be generalizable to other jurisdictions with different legislative frameworks. The decision to focus on elements of the Victorian law was to gather an evidence-base that could be used by local health services prior to VAD implementation. In addition, while the Victorian legislation is novel, the Act does compare to regulatory requirements with laws recently passed in other jurisdictions, such as Western Australia(35) where nurse practitioners have legal authority to administer VAD.

## Conclusion

Our study investigated clinicians' support for and willingness to be involved in VAD, and associated factors that may impact on clinician support for the legalization of VAD, in particular physicians' willingness to provide VAD in practice once legal. Most participants (73%) surveyed supported the introduction of Victoria's VAD legislation; the strongest significant predictor of support was clinical role, with nurses and allied health staff having significantly greater odds of supporting the legalization of VAD, compared to medical specialists. Further, this translated to only a small number (<60) of medical specialists from high-impact specialties who were willing to participate beyond continuing to provide usual medical care. Given their role in caring for people most likely to seek VAD, this may translate into potential access issues for patients requesting VAD in accordance with the legal requirements in Victoria. It is a significant

consideration where health services may need to engage with and provide additional support to the staff most likely to be involved in VAD.

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Table 1. Participant Characteristics and Support for Victoria's legalisation of VAD

| | | Support for legalisation of VAD† | | | |
|---|---|---|---|---|---|
| | Overall ‡ | Yes | No | Unsure | I prefer not to say |
| Number of Participants | 5159 | 3768 (73.0%) | 623 (12.1%) | 712 (13.8%) | 56 (1.1%) |
| Age | | | | | |
| 30 or below | 1460 (28.3%) | 1120 (76.7%) | 143 (9.8%) | 191 (13.1%) | 6 (0.4%) |
| 31-40 | 1324 (25.7%) | 962 (72.7%) | 159 (12.0%) | 188 (14.2%) | 15 (1.1%) |
| 41-50 | 1073 (20.8%) | 760 (70.8%) | 143 (13.3%) | 156 (14.5%) | 14 (1.3%) |
| 51-60 | 868 (16.8%) | 642 (74.0%) | 105 (12.1%) | 112 (12.9%) | 9 (1.0%) |
| 60+ | 330 (6.4%) | 228 (69.1%) | 42 (12.7%) | 53 (16.1%) | 7 (2.1%) |
| Prefer not to say | 104 (2.0%) | 56 (53.8%) | 31 (29.8%) | 12 (11.5%) | 5 (4.8%) |
| Gender | | | | | |
| Female | 4010 (77.7%) | 3023 (75.4%) | 397 (9.9%) | 552 (13.8%) | 38 (0.9%) |
| Male | 1045 (20.3%) | 700 (67.0%) | 188 (18.0%) | 147 (14.1%) | 10 (1.0%) |
| Other | 4 (0.1%) | 4 (100.0%) | 0 (0.0%) | 0 (0.0%) | 0 (0.0%) |
| Prefer not to say | 96 (1.9%) | 38 (39.6%) | 38 (39.6%) | 12 (12.5%) | 8 (8.3%) |
| Unknown | 4 (0.1%) | 3 (75.0%) | 0 (0.0%) | 1 (25.0%) | 0 (0.0%) |
| Role (grouped) | | | | | |
| Medical specialist | 619 (12.0%) | 314 (50.7%) | 178 (28.8%) | 113 (18.3%) | 14 (2.3%) |
| Doctor-in-training | 525 (10.2%) | 318 (60.6%) | 109 (20.8%) | 96 (18.3%) | 2 (0.4%) |
| Nurse | 2844 (55.1%) | 2240 (78.8%) | 231 (8.1%) | 348 (12.2%) | 25 (0.9%) |
| Allied health other | 714 (13.8%) | 555 (77.7%) | 57 (8.0%) | 95 (13.3%) | 7 (1.0%) |
| Pharmacists | 203 (3.9%) | 139 (68.5%) | 26 (12.8%) | 35 (17.2%) | 3 (1.5%) |
| Other clinical staff | 254 (4.9%) | 202 (79.5%) | 22 (8.7%) | 25 (9.8%) | 5 (2.0%) |
| Frequency of looking after incurable illness patients | | | | | |
| Daily | 896 (17.4%) | 607 (67.7%) | 139 (15.5%) | 138 (15.4%) | 12 (1.3%) |

| | | | | | |
|---|---|---|---|---|---|
| At least once per week | 1279 (24.8%) | 973 (76.1%) | 130 (10.2%) | 165 (12.9%) | 11 (0.9%) |
| At least once per month | 1127 (21.8%) | 817 (72.5%) | 148 (13.1%) | 150 (13.3%) | 12 (1.1%) |
| Less frequent than once per month | 1407 (27.3%) | 1025 (72.9%) | 164 (11.7%) | 200 (14.2%) | 18 (1.3%) |
| Never | 450 (8.7%) | 346 (76.9%) | 42 (9.3%) | 59 (13.1%) | 3 (0.7%) |
| Awareness of VAD legislation | | | | | |
| Yes, I had extensive knowledge | 958 (18.6%) | 626 (65.3%) | 231 (24.1%) | 86 (9.0%) | 15 (1.6%) |
| Yes, I had heard of it, but only had limited knowledge | 3780 (73.3%) | 2858 (75.6%) | 352 (9.3%) | 532 (14.1%) | 38 (1.0%) |
| No, I was not aware of the legislation | 421 (8.2%) | 284 (67.5%) | 40 (9.5%) | 94 (22.3%) | 3 (0.7%) |

† percentages calculated within the row for each Question/Role
‡ percentages calculated across the column for each Question/Role
Abbreviations: VAD, voluntary assisted dying

Table 2. Multivariable analysis of association with support for VAD –
Model 1: All clinicians (n=5169), Model 2: Medical Specialists only (n=619)

| Demographic Variable | 1. All Clinicians (n=5169) | | | | 2. Medical Specialists only (n=619) | | | |
|---|---|---|---|---|---|---|---|---|
| | Odds Ratio | 95% CI LB | 95% CI UB | *p* | Odds Ratio | 95% CI LB | 95% CI UB | *p* |
| Role | | | | | | | | |
| Medical Specialist | 1 | - | - | - | | | | |
| Junior Doctor | 1.11 | 0.85 | 1.46 | 0.431 | | | | |
| Nurse | 3.34 | 2.70 | 4.13 | <0.001 | | | | |
| Allied Health | 3.13 | 2.41 | 4.06 | <0.001 | | | | |
| Pharmacist | 1.80 | 1.26 | 2.56 | 0.001 | | | | |
| Other Clinical Staff | 3.66 | 2.56 | 5.25 | <0.001 | | | | |
| Specialty Type | | | | | | | | |
| Low Impact Specialty | | | | | 1 | - | - | - |
| High Impact Specialty | | | | | 0.49 | 0.32 | 0.78 | 0.002 |
| Geriatrics / Palliative Care | | | | | 0.32 | 0.17 | 0.57 | <0.001 |
| How long in role? | | | | | | | | |
| Less than 10 years | | | | | 1 | - | - | - |
| 10-20 years | | | | | 1.32 | 0.80 | 2.19 | 0.274 |
| More than 20 years | | | | | 2.01 | 1.00 | 4.03 | 0.049 |
| Prefer not to say | | | | | 0.08 | 0.01 | 0.70 | 0.023 |
| Meet 5 year fellowship criteria | | | | | | | | |
| Yes | | | | | 1.09 | 0.67 | 1.78 | 0.726 |
| No | | | | | 1 | - | - | - |
| I prefer not to answer | | | | | 0.63 | 0.18 | 2.20 | 0.473 |
| Age Group | | | | | | | | |
| 30 or below | 1.43 | 1.07 | 1.91 | 0.016 | - | - | - | - |
| 31-40 | 1.19 | 0.90 | 1.58 | 0.220 | 1.40 | 0.61 | 3.26 | 0.429 |
| 41-50 | 1.03 | 0.78 | 1.37 | 0.814 | 0.88 | 0.44 | 1.76 | 0.716 |
| 51-60 | 1.08 | 0.80 | 1.44 | 0.623 | 1.04 | 0.56 | 1.96 | 0.895 |
| >60 | 1 | - | - | - | 1 | - | - | - |
| Prefer not to say | 0.85 | 0.51 | 1.43 | 0.539 | 1.90 | 0.57 | 6.29 | 0.293 |
| Frequency looking after incurable illness patients | | | | | | | | |
| Daily | 1 | - | - | - | 1 | - | - | - |
| At least once per week | 1.49 | 1.22 | 1.81 | <0.001 | 1.18 | 0.71 | 1.97 | 0.530 |
| At least once per month | 1.19 | 0.98 | 1.46 | 0.083 | 0.99 | 0.57 | 1.71 | 0.972 |
| Less frequent than once per month | 1.19 | 0.98 | 1.45 | 0.077 | 0.88 | 0.52 | 1.49 | 0.628 |
| Never | 1.39 | 1.05 | 1.82 | 0.019 | 0.86 | 0.37 | 1.97 | 0.717 |
| Awareness of VAD legislation | | | | | | | | |
| Yes, I had extensive knowledge | 1 | - | - | - | 1 | - | - | - |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Yes, I had heard of it, but only limited knowledge | 1.25 | 1.06 | 1.48 | 0.008 | 1.27 | 0.88 | 1.84 | 0.195 |
| No, I was not aware of the legislation | 0.70 | 0.54 | 0.91 | 0.008 | 1.55 | 0.56 | 4.31 | 0.403 |

Abbreviations: VAD, voluntary assisted dying; LB, lower bound; UB, upper bound

Table 3. Participant's willingness to conduct role associated with VAD (n=5159)

| Role / Task Number | Task Description | Yes | No | Unsure | No Response |
|---|---|---|---|---|---|
| Senior Medical Staff (n=619) | | | | | |
| 1.1 | Provide medical care to a patient who has requested VAD | 476 (76.9%) | 76 (12.3%) | 47 (7.6%) | 20 (3.2%) |
| 1.2 | Be a consulting physician to give an opinion on patient eligibility for VAD (including capacity) | 228 (36.8%) | 274 (44.3%) | 95 (15.3%) | 22 (3.6%) |
| 1.3 | Be a Co-ordinating Practitioner – assess and if the patient fits criteria (including capacity), write a prescription for VAD oral medication | 127 (20.5%) | 369 (59.6%) | 97 (15.7%) | 26 (4.2%) |
| 1.4 | Be a Co-ordinating Practitioner – assess and if the patient fits criteria (including capacity), prescribe and administer VAD injection | 93 (15.0%) | 402 (64.9%) | 99 (16.0%) | 25 (4.0%) |
| 1.5 | Be a co-ordinating physician - insert the IV cannula | 132 (21.3%) | 386 (62.4%) | 76 (12.3%) | 25 (4.0%) |
| 1.6 | Be present at a VAD death | 223 (36.0%) | 270 (43.6%) | 103 (16.6%) | 23 (3.7%) |
| Junior Doctors (n=525) | | | | | |
| 2.1 | Provide medical care (not VAD) to patient who has requested VAD | 478 (91.0%) | 18 (3.4%) | 11 (2.1%) | 18 (3.4%) |
| 2.2 | Put in an IV cannula for the VAD injection | 283 (53.9%) | 131 (25.0%) | 91 (17.3%) | 20 (3.8%) |
| 2.3 | Be present at a VAD death | 278 (53.0%) | 126 (24.0%) | 102 (19.4%) | 19 (3.6%) |
| Nurses (n=2,844) | | | | | |
| 3.1 | Provide nursing care to patient who has requested VAD | 2553 (89.8%) | 98 (3.4%) | 112 (3.9%) | 81 (2.8%) |
| 3.2 | Put in an IV cannula for the VAD injection | 1821 (64.0%) | 559 (19.7%) | 340 (12.0%) | 124 (4.4%) |
| 3.3 | Draw up VAD drugs but not injecting | 1848 (65.0%) | 512 (18.0%) | 390 (13.7%) | 94 (3.3%) |
| 3.4 | Provide nursing care to a patient who has taken the VAD oral medication but has not yet died | 2437 (85.7%) | 155 (5.5%) | 167 (5.9%) | 85 (3.0%) |
| 3.5 | Be present at a VAD death | 2125 (74.7%) | 269 (9.5%) | 369 (13.0%) | 81 (2.8%) |
| Pharmacists (n=203) | | | | | |
| 4.1 | Dispense a prescription for a VAD substance, including informing a | 106 (52.2%) | 49 (24.1%) | 44 (21.7%) | 4 (2.0%) |

| | | | | | |
|---|---|---|---|---|---|
| | person how to self-administer the VAD substance. | | | | |
| Neuropsychologists (n=36) | | | | | |
| 5.1 | Provide advice on whether a patient has decision-making capacity in relation to VAD. | 27 (75.0%) | 2 (5.6%) | 6 (16.7%) | 1 (2.8%) |
| Other Clinical Staff (n=932)† | | | | | |
| 6.1 | Provide care to patient who has requested VAD | 776 (83.3%) | 37 (4.0%) | 82 (8.8%) | 37 (4.0%) |
| 6.2 | Provide care to a family of a patient who has requested VAD, knowing that there may be some family members who do not agree with the patient's decision | 760 (81.5%) | 28 (3.0%) | 111 (11.9%) | 33 (3.5%) |

† Includes Allied Health (excluding Pharmacists and Neuropsychologists)

Abbreviations: VAD, voluntary assisted dying

Table 4. Multivariable Logistic Regression Models† for associations between willingness‡ to participate in VAD activities and reasons underlying their decision to participate in VAD: Senior Medical Staff (N=563)

| Reasons[#] | Odds Ratio | 95% CI LB | 95% CI UB | *p* |
|---|---|---|---|---|
| Giving patients access to a legally sanctioned medical intervention | 5.24 | 3.44 | 7.98 | <0.001 |
| Respecting a patient's right to request VAD | 8.95 | 5.32 | 15.03 | <0.001 |
| Allowing patient to choose time of death | 5.29 | 3.54 | 7.91 | <0.001 |
| Relieving patient suffering | 4.04 | 2.27 | 7.21 | <0.001 |
| Your personal values | 0.39 | 0.27 | 0.57 | <0.001 |
| Your cultural beliefs | 0.35 | 0.23 | 0.52 | <0.001 |
| Your religion/spirituality | 0.21 | 0.13 | 0.34 | <0.001 |
| Your obligations to the patient requesting VAD | 2.63 | 1.75 | 3.96 | <0.001 |
| Your obligations to patients other than the individual requesting VAD, including future patients | 0.93 | 0.65 | 1.34 | 0.693 |
| Concerns about increased workload to you | 1.02 | 0.62 | 1.68 | 0.936 |
| Your perceived emotional burden on you if you participate | 0.55 | 0.38 | 0.81 | 0.002 |
| Relationships with colleagues | 0.82 | 0.53 | 1.26 | 0.369 |
| Relationship with other patients | 0.73 | 0.49 | 1.07 | 0.110 |
| Your obligation to your colleagues | 1.38 | 0.93 | 2.04 | 0.111 |
| Your obligation to the hospital as your employer | 1.25 | 0.80 | 1.94 | 0.330 |
| Current uncertainty about practicalities | 0.76 | 0.53 | 1.10 | 0.148 |

†Table provides results of 16 separate multivariable models including each of the 16 reasons in addition to the variables of site, gender, age, specialty (i.e. low impact, high impact and palliative) and years in role

‡Willingness to be either a consulting or coordinating practitioner (answered 'yes' to at least one item 2-4); respondents answering unsure to all 3 of these items were excluded from the analysis (n=34)

[#] Reason indicated as 'very important' or 'of the utmost importance'

Abbreviations: VAD, voluntary assisted dying; LB, lower bound; UB, upper bound