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Still safe; still respectful: a mixed methods study exploring the early experiences of a rural community hospice in providing voluntary assisted dying

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Abstract

Background Voluntary assisted dying has become available as an end-of-life choice in many countries, including Australia. There is evidence on the mixed impact of voluntary assisted dying legislation on palliative care healthcare professionals, however, less is known about the interface between palliative care and voluntary assisted dying in smaller rural settings. This study explored the experiences of staff at a hospice in rural Western Australia in the two years following the implementation of voluntary assisted dying legislation.

Methods A mixed-methods research methodology was used, with data collected via a brief anonymous survey and semi-structured interviews conducted with hospice staff in one rural location in Western Australia. Survey data was exported into SPSS and descriptive statistics were performed. Interviews were audio recorded and after deidentification, the transcripts were analysed thematically.

Results A total of 30 participants took part in the survey and 10 were interviewed. The majority ($n = 19$) of survey respondents had been involved in voluntary assisted dying, yet only seven reported that their day-to-day role had changed. Supporting patient choice and autonomy were the most cited benefits of the introduction of voluntary assisted dying. Analysis of the qualitative data yielded three main themes: everyone is involved with patients accessing VAD; nothing changes but everything changes; and perceived support, education and training needs.

Conclusions This study has described day-to-day work and experiences of those working in a small rural hospice which has integrated VAD into the care offered within the facility, observing there are subtle changes in the organisational atmosphere when VAD occurs. The education and support activities in place and the noted gaps may be a useful checklist for other hospices in the early phases of integrating VAD into their facility. Recommendations for future research are made.

Keywords Death assisted, Death with dignity, Respect, Hospice care, Qualitative research, Health policy

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Background

Across jurisdictions where Voluntary Assisted Dying (VAD) or Medical Assistance in Dying (MAiD) has become available as an end-of-life choice, the interface of palliative care (PC) and VAD has been a new frontier with research exploring the experience of hospice staff before and shortly after VAD implementation in their workplace.

Studies focusing on the experience within Canadian hospices between one and four years post-implementation of MAiD have reported mixed impact on PC healthcare professionals [1–3]. Positive changes reported include the ability to offer a new option for end-of-life care with a focus on autonomy and patient and family comfort [1, 2]; more supportive collegial relationships and team debriefing; more public conversations about dying; extended professional learning; improved processes; and opportunities for strong leadership from within their institution [1, 3]. In contrast, challenges include the impact of MAiD on the identity and purpose of hospice; the difficulty reconciling patients' interest in MAiD and clinicians' own beliefs about PC; and tension in delivering care [2]. Additional challenges were related to experiences of provider distress; family distress; interprofessional team conflict; and a concern about the potential for MAiD having a negative impact on PC [4]. Furthermore, psychological and professional support was seen as inadequate in some facilities with recommendations for improved education and training around the actual legislation as well as around MAiD-specific communication skills [5, 6]. Other support needed included more debriefs as well as tailored bereavement support for families [4].

Gerson et al. interviewed PC providers across countries with three to 23 years of assisted dying legislation to explore the relationship between PC and assisted dying over time [6]. Respondents from all jurisdictions reported that public education about PC needed strengthening, however the integration of PC and assisted dying seemed to evolve with long-established services having a shared alignment around relief of suffering while those with newer legislation more likely to report tension at the interface of assisted dying and PC. Overall, the authors suggest "there is a clear need for more attention to how PC and assisted dying can co-exist, where both are available" (p.3537) [6].

Fewer studies have explored the relationship between assisted dying and PC in rural healthcare systems. One study reviewed MAiD policy documents in Canada and described unique rural considerations outside the usual equity of access to healthcare concerns [7]. These authors reported that there is the potential for less privacy; complexity due to dual relationships between staff, patients and families in smaller communities; and the lack of policy guidance about telehealth use [7]. They highlighted access to an appropriate rural place to access assisted dying as important for dignity and timeliness. Collins and Leier argue for specific consideration for practitioners in rural and remote areas, concerned that assisted dying could harm rural PC as the interface for the few rurally based doctors would complicate their work, split resources, or result in obligation to participate because rural people do not want to go elsewhere to die [8]. Winters et al. note that such difficulties are real for rural providers of assisted dying in Canada with a new significant time burden from paperwork, communication and management on the day of death; lack of clear guidelines; not enough providers; and strained relationships between providers and conscientious objectors early on [3].

The potential impact of VAD on whole team dynamics in the smaller sized PC teams working rurally is not well understood, although the risk of negative impact could be presumed as refractory suffering is established as a potential cause of PC team fracturing [9].

In Western Australia (WA), the Voluntary Assisted Dying Act [10] was passed by Parliament in December 2019 with full enactment of the legislation in mid-2021. At that time, there was minimal guidance available to support smaller community-owned, not for profit hospices as to whether to support VAD within their facilities, how to make these decisions with rural communities and how to support staff during that process. The Albany Community Hospice (ACH) is one such rural facility. VAD was implemented by ACH in 2021 following a period of community and staff consultation which highlighted the expectation that hospice would remain a "safe place" [11] and Board deliberation which prioritised respect for patients' choices [12]. While there was strong support for the enactment of the VAD legislation across WA, the Albany community did not advocate for or request VAD to be implemented in ACH, and previous work in this area found that there was not a consensus view on community expectation in Albany among Hospice staff and volunteers and community members [11].

This study explores the experiences of the work of staff and volunteers at ACH two years post-implementation of VAD. The objectives were:

1. To describe the perceived impact of VAD practice on roles and day-to-day tasks in a rural hospice;
2. To explore any perceived challenges at the interface of PC and VAD, and potential solutions; and.
3. To explore how the organisation can optimise its ongoing support of staff and volunteers, including the identification of education and training needs.

Methods

Research team

The research team consisted of the authors of this paper and an experienced interviewer. KA is a palliative medicine academic physician who provides specialist consultation to General Practitioners (GPs) at ACH and is a medical advisory committee volunteer. TP has a long career in public health research, especially in community programmes and has no formal links to ACH. BCB is a qualitative researcher with no links to ACH. The interviewer (CG) is an independent consultant who worked in local government and community development and has previously facilitated workshops to develop ACH's strategic plan and interviews and focus groups for the two preceding papers [11, 12]. KA, TP and CG are rurally based. The team support VAD legislation but do not participate in VAD service provision.

The organisation

The hospice has a 34-year history within a town of ~ 35,000 people, 400 km south of Perth in WA and is the only remaining community-owned hospice operating in the state. It is a secular, fully accredited, eight-bed, free-standing unit with specialist nursing care, managed by a nine-member volunteer Board of Management. Nursing, personal and pastoral care is provided by nurses, patient care assistants and volunteers, with nonclinical support from administrators, cooks and cleaners. Medical care is provided by visiting GPs and a visiting PC specialist (KA) [13].

Sampling and recruitment

All staff, visiting doctors and volunteers were invited to complete an online survey about their experiences with VAD. Recruitment was through the provision of study information and the survey link using word of mouth, flyers on staff notice boards, newsletter, agenda items at staff meetings and personal emails. On completion of the online survey, participants were invited to nominate to be interviewed at a time and place convenient for them. Those who nominated to be interviewed were emailed more information and a consent form.

Data collection

Data were collected through the online questionnaire and semi-structured interview. The survey consisted of nine questions with demographic questions and dichotomous items (yes/no) related to VAD developed by the authors following literature review (see Appendix 1). Semi-structured interviews were conducted in person to explore these responses in more detail. Interviews were conducted by an experienced interviewer (CG) between January and February 2024, using a standard guide that included questions about their work at ACH as well as their experience of the implementation of VAD in Hospice (see Appendix 2 for full list of questions). The interview guide for the ACH Clinical Manager had two further questions included related to staff turnover and reasons for staff leaving. The interviews were voice recorded and transcribed by an independent professional transcribing service. The transcriptions were de-identified by a member of the research team (TP) and two interviewees who requested an opportunity to review and approve their transcript were sent their individual transcript prior to analysis.

Data analysis

Quantitative data from the online questionnaire were analysed descriptively using SPSS (version 29.0.0). Qualitative data was analysed thematically with the researchers reading and re-reading the interview transcripts to develop codes. Following code development, KA and TP independently conducted a detailed process of sorting and tagging the data into these codes highlighting key words, sentences and/or paragraphs in the transcripts. These coded transcripts were then compared, and any discrepancies discussed until agreement was reached. The transcripts were then revisited by all authors to further refine the coding and identify broad themes. Fourteen respondents made free text comments in the survey which were reviewed alongside interview transcripts to triangulate; however, these were only included in the thematic analysis when they extended the analysis, noting that most free text respondents were also included as interviewees.

As the hospice is a small organisation with staff and volunteers who know each other and their individual views on VAD well, quotes in the final manuscript from any individual are denoted by number (e.g. #1) with no further designations such as gender or role, to reduce the likelihood of re-identification and to protect the confidentiality of those involved. During analysis the authors ensured that the breadth of all interviewees' responses was considered in the selection of quotes.

Ethics

Ethics approval was granted through the University of WA Human Research Ethics Committee (2023/ET00822).

Results

The online survey was distributed to 133 hospice staff, doctors and volunteers, with 30 respondents (response fraction = 22.6%).

The demographic information of respondents is shown in Table 1. Nineteen respondents (63%) reported that they had provided support for a person choosing VAD and seven (23.3%) felt their day-to-day work or role had

Table 1 Demographic information for online survey respondents (total responses $n = 30$)

Role:	% (*n*)
Clinical staff	56.7 (17)
Volunteer	33.3 (10)
Non-clinical staff (e.g. kitchen, finance, cleaning, business management)	10.0 (3)
Gender:	
Woman/female	70.0 (21)
Man/male	20.0 (6)
Other*	10.0 (3)
Age*:	
< 50	30.0 (9)
50-<60	20.0 (6)
60+	43.3 (13)
Length time at ACH:	
< 1 year	13.3 (4)
1–5 years	43.3 (13)
More than 5 years	43.3 (13)

*missing = 2

changed since VAD was available at the Hospice. Only one respondent felt there had been no benefits from the implementation of VAD within hospice, with others indicating benefits including ability to offer increased end-of-life choices at the hospice ($n = 26$), more support for patient autonomy ($n = 24$), more open conversations about end-of-life choices ($n = 24$), VAD and PC becoming complementary ($n = 24$), new learnings about themselves ($n = 22$), deeper collegial relationships ($n = 18$), and increased work satisfaction ($n = 17$).

Respondents noted that there were several processes that were important in supporting their work relative to VAD. These included having an organisational policy about how VAD occurs ($n = 25$); leadership from the senior clinical team ($n = 25$) and the Board ($n = 21$); support for involvement in the care of patients accessing VAD as per personal preference ($n = 22$); and the availability of confidential free counselling through the organisation ($n = 23$). Other activities such as education about VAD ($n = 24$), debrief sessions ($n = 20$), and attendance at the weekly multidisciplinary care planning meetings ($n = 14$, note this is only open to clinical staff) were also indicated to be useful.

Fourteen of the survey respondents indicated they were interested in an interview and of these, 10 were successfully recruited. Six interviewees had clinical roles, two non-clinical roles and two were volunteers. All were female with a mean age of 53 years old (range 32–76). Three had been at ACH for over five years, six had commenced between one and five years previously (during the time VAD legislation was introduced into ACH), and one had been there for less than one year. The interviews ran for a mean of 31 min.

Three main themes were identified: (1) everyone is involved with patients accessing VAD; (2) nothing changes but everything changes; and (3) perceived support, education and training needs.

Everyone is involved with patients accessing VAD

Participants' accounts of their experiences showed that all were impacted by the implementation of VAD to varying degrees, insofar as they felt they were all involved in the care of patients accessing VAD. They also spoke about being aware when VAD was going to take place in the facility, and this was regardless of their specific role in the VAD process and their personal attitudes towards VAD.

Awareness and involvement regardless of role

Participants described different roles and levels of involvement in the implementation of VAD however they all discussed some way in which they perceived they were involved in the care of patients accessing VAD or the implementation of VAD processes more broadly. Participants' descriptions of their direct involvement in VAD ranged from the collection of admission clerical information, personal interactions such as conversations with family members, providing nursing or medical care to the patient, being present when family rituals or celebrations were held before VAD, or being in the room as VAD was administered and the person died.

Those who reported having been present at the moment of death tended to regard this experience as a privilege, as this quote reflects:

> *"So I was lucky enough to have the experience that one of my patients allowed me to be there, when she had her VAD. And it was really lovely. It was kind of like having a living wake. So she had all her family here and just passed away really, really peacefully." (#10).*

Those who did not play a direct role in the day-to-day care and support of patients and families also saw themselves as actively involved in the implementation of VAD. One such participant spoke about her strategic role in the initial stages of development of required processes:

> *"I was directly involved with developing the processes and the guidelines to implement voluntary assisted dying." (#1).*

Another participant spoke about her liaison and coordination role, which she described as:

> *"... supporting somebody through the assessment process and supporting the staff through that patient's*

> *journey and liaising with the VAD state-wide care navigator service, liaising with the patient's GP, whether they were or were not going to be part of the assessment process. And then liaising with the VAD coordinating, the consulting and the administering practitioners and then the family." (#9).*

Attitudes towards VAD

Although attitudes towards VAD among staff and volunteers were not specifically explored, participants' accounts revealed a range of attitudes towards VAD. In the main, attitudes were supportive; however, there were some who expressed some degree of ambivalence, and one strong opposing voice was also noted. Those who expressed their support of VAD were influenced by their attitudes towards patient choice, reducing suffering and giving patients control. With regards to primacy of patient choice, one participant expressed this:

> *"I actually remain very clear and very firm that if a person wants that, then they should have that because I just believe in our – we give patient choice in all decisions relating to their care. What is the difference? This is just yet another one of those choices as long as it's informed." (#9).*

Other participants noted that their current attitudes were formed over time by coming to believe that VAD reduced suffering at the end-of-life. One participant explained:

> *"One thing I struggle with is people suffering, so when I see someone suffering, that's what keeps me awake, that's what keeps me thinking when I leave work. And that they might not know that this (VAD) is an option and that's the thing that plays on my mind is the suffering." (#6).*

VAD was, thus, broadly perceived as a valid option or choice available to patients as part of their PC in the context of end-of-life suffering. In reflecting of the role of VAD in PC, one participant described her experience of the impact of this choice being made available on both the patients and on herself as a health professional:

> *"I just have always felt that there's been a place for [VAD] in palliative care because I've seen so much end-of-life suffering and people asking for this and not getting it, so that when I actually see people being approved, it's almost like you see the weight lifted off them. And we're the fixers, aren't we? Nurses and doctors, we like to fix people. So for me that is a personal satisfaction of fixing something that is absolutely unfixable otherwise." (#9).*

Linked to the notion of respect for patient's autonomy and patient choice, some perceived VAD as giving patients some control over their end-of-life. However, some noted that due to the unpredictable nature of terminal illness, VAD *"may give an illusory sense of control"* (online survey).

In contrast with the rest of the sample, one participant expressed a strong stance against VAD, noting that VAD had *"devalued"* (#4) people who are towards the end-of-life. This participant described experiencing significant distress when the organisation made the decision to support the implementation of VAD; also noting that their attitude towards VAD had not changed since implementation. Despite feeling morally challenged, this participant felt that their views were respected and supported by the organisation.

Nothing changes but everything changes

Changed atmosphere when VAD is occurring in hospice

Whilst participants from the survey and interviews seemed keen to highlight that nothing much had changed within the organisation (including their reports of the impact of VAD on the day-to-day work), the interview accounts showed a shared perception that there was a changed atmosphere within the facility on the days that VAD occurred - a subtle change that some struggled to describe but that was felt by all. For example, one participant noted:

> *"There's definitely a different feel at the time". (#3)*

Another participant said *"it's almost like that feeling of impending execution" (#6)*, noting the impact of the different atmosphere on all staff:

> *"What surprised me is how much it affects the staff on that shift, even if they're not directly involved or in the shifts around the time where somebody decides that that's when they'd like to leave." (#6).*

As the quote above highlights, survey respondents and interview participants acknowledged that this was experienced by all staff, not just the clinical staff directly involved in caring and supporting the patient and their family on the day:

> *"We have patient care assistants working in the kitchen, sometimes volunteers… it can be quite confronting if they haven't had a chance to think about it beforehand. And it's emotional no matter what you do." (#3).*
> *"When VAD is known and imminent in Hospice, there is a definite shift to how clinical staff work, react and feel and the feeling in Hospice changes to*

> *from our usual going-ons. As a non-clinical member of staff here, I do not know how to support our clinical staff as it is a lot for them to deal with. During this time, I have noticed that it also changes how I work, knowing that a patient is choosing to end their life and how heavy a decision that must be on them and their family. It is a reflective time on lots of levels." (online survey).*

Impact on day-to-day work and roles

All interview participants and the majority of survey respondents (76.7%) reported that their day-to-day work had not changed significantly since the implementation of VAD in the organisation. However, in apparent contradiction, they subsequently described the different ways in which their work had indeed changed.

VAD was broadly regarded as a part of PC. In this context, participants reported that little, if anything, had changed in their roles or the skillset required, insofar as they were still providing care at the end-of-life:

> *"No, no. My work hasn't changed... So the work hasn't directly changed because we still continue to provide the service... at the end of the day, they're providing care to someone at end-of-life. So whether it's a planned death or an unknown death, their support is still the same. So I don't think there has been a huge impact... It's different but not..." (#1).*

One participant explained:

> *"But I think that the work of death and dying is the same for any Hospice. Every hospice would have the skills to manage acute grief, complicated grief, family dynamics, anticipation of an event coming. We all have those skills and basically that's what voluntary assisted dying pulls together." (#9).*

The same participant explained that a person approved for VAD would be placed on a death-approaching care plan, and supporting the patient and their family for death and bereavement would be approached in a case-by-case basis, *"whether it's VAD or not VAD" (#9).*

However, there was a shared perception that staff took special care to accommodate the needs of patients who had been approved for VAD and their families:

> *"So a person who's terminally ill has to consciously work through that process and that there's been quite a lot to get to that point for them. But also there is a build-up here that you feel leading to the timing and that's happening. And everyone is going out of their way to be so accommodating which happens anyway. But obviously with the natural death you don't know when it's going to happen so I don't know whether that's a different." (#8).*
>
> *"You have to be a little bit more perhaps tuned in and aware of the family and what they're going through." (#7).*

So whilst participants generally initially reported that the implementation of VAD within the organisation had not fundamentally changed their day-to-day work, their accounts revealed that they had, on reflection, been required to develop new skills and knowledge or perform new tasks. When new skills were required in their role, these included being able to respond to new conversations with patients, families and colleagues; becoming familiar with new requirements under legislation; being able to integrate new logistical impacts from the VAD assessment and administration processes into patient care; developing stronger skills in supporting others; and new self-care skills and behaviours.

The planned nature of VAD also gave rise to new considerations and aspects to the role of staff and volunteers, such as ensuring they were not rostered on or in the building at the time of a planned VAD death; coming in on days off to say goodbye; and supporting preparations for the VAD death such as *"making the room nice"* (#1), having *"a little celebration"* (#5), preparing a *"special"* last meal (#5) or assisting with clothes. It was acknowledged that "*because you know it's coming up and it's like - do you want to do anything special?"* (#6).

Those that previously felt less aware of the imminent nature of a person's death due to their nonclinical roles reported that organisational processes around communication had changed, with weekly updates on the status of patients, including any upcoming VAD. Perceptions of the need for this information to be communicated varied, and whilst some were supportive, others found it unnecessary, as this quote reflects:

> *"At that meeting, it has been brought up that someone may be accessing or being told that someone is accessing VAD. Now I find that a bit of a challenge because we don't get told if anyone else has been put on a syringe driver or is going downhill, but yet there's very much this heightened, oh, it's VAD's happening and I don't feel that that necessarily we need to know that information." (#1).*

Reflecting on their expectations of what the impact of implementing VAD would mean for them and for their organisations, some expressed surprise that the number of people taking up VAD was lower than they expected, but also that the time required to organise paperwork, assessments and administration per person was longer

Table 2 Types of support identified by interviewees as in place and valued

Support type	Examples in place
Leadership from Board	Supporting community consultation process
	Formal meeting with staff to announce final policy decision
	Individual meetings with concerned staff by Chairperson
	Formal review of policy at 12 months
Leadership from senior clinical team	Support for an open culture
	Appointment of senior clinician as VAD coordinator for first VAD deaths
	Individual meetings with concerned staff by Manager
	Support from Medical Advisory Committee
	Broadening usual support activities that were available for staff and volunteers to include VAD deaths
	Routine and frequent checking in with involved staff
	Exploring impact of VAD at exit interviews
Policies and procedures	Availability of free confidential counselling (Employee Assistance Program)
	Policy support for varying levels of engagement with VAD
	Hospice-specific VAD guidelines
Support from other members of the MDT	Talking with each other
	Other clinicians coming to family meetings
	Being asked if OK
	Support coming "on the job"
	Discussion at handovers
Liaison with other organisations	State-based VAD coordination service
	Forming new community-based hospice networks
	Learning from the experiences of other organisations
New support activities that have developed over time	Post-death MDT debriefs
	Formal monthly group sessions with external psychologist
	Continually open confidential online feedback form for staff and volunteers

than they expected. For example, the extra work involved in completing VAD paperwork was noted.

Overall, even if they thought that the content of their work had not changed significantly, staff and volunteers acknowledged that their feelings about the day-to-day work had changed. These reported changes tended to reflect their attitudes towards VAD, and whilst many reported increased job satisfaction or a greater sense of privilege (with one participant describing supporting a patient through VAD as *"almost life changing"* (#5)), one participant lamented that *"palliative care isn't – it's not the same"* (#4), adding that their passion for PC had diminished.

Table 3 Education and training available in hospice that are perceived as useful

Education and training type	Examples found useful
Self-directed learning	Talking to more experienced colleagues
	Completing own reading
	Online modules
	Watching videos and documentaries
	Observing others as they work
Formal education	Postgraduate medical training
	State-based VAD training for practitioners under the Act (Only available to those training for duties under the Act)
Hospice-delivered education	Question and answer sessions with clinicians who had been involved with the process in other jurisdictions
	"Scripts" to support communication with patients and families
	Learning from each other
	Education sessions around Hospice policies and frameworks
	Formal mentorship of interested nurses into VAD coordinator roles
	Handouts about the VAD process
	Posters about VAD resources in staff room
	Handouts about "what is a VAD first request"
	Lectures and presentations
Related education topics that were considered useful	Advance Care Planning
	Confidentiality
	Palliative Care principles
	Active listening skills
	Medical ethics (Autonomy, capacity, consent, supported decision-making mentioned)

Perceived support, education and training needs

Support mechanisms in place

Interviewees described many supportive activities and resources that they valued as important once VAD was an option for patients in hospice. These are included in Table 2.

Communication within the multidisciplinary team (MDT) and internal organisational communication was described as 'supportive' if it was based in *"kindness and respect"* (#8), *"open"* (#3 and 9) and *"transparent"* (online survey).

Education and training needs that were met

Many forms of education and training were recalled as effective by interviewees (see Table 3). Some discussed that as experienced workers within a small, rural-based community hospice, they were already well trained in areas such as maintaining confidentiality, setting boundaries, and managing personal connections with patients and families, and that the implementation of VAD did not require new training in these domains.

The best learning was felt to be through observation of more experienced practitioners in their role.

> *"I don't know if that's something you can train or if you can just invite them into the conversation if there is a discussion with a family because I think that's almost the best training. I've attended education sessions where they try to teach you how to tell parents that their children are dying and it's just totally pointless. You need to sit opposite the parents and have the conversation and listen into experts who have had that conversation many a times you can't play that in a role play." (#5).*

Gaps identified

Some reported that these activities were sufficient where others requested more support, either in developing new skills (e.g. new communication skills), managing difficult conversations between colleagues with different views about VAD, clearer guidelines on who to escalate to if all senior clinical staff are considered to be very pro-VAD, more frequent debrief opportunities that also included nonclinical staff, or adequate financial reimbursement for the time taken to complete VAD assessments and paperwork.

There were also recommendations made that VAD education and training should be an ongoing process, not just concentrated at the initial implementation phase within the organisation, and that there should be opportunities for new clinicians and volunteers to learn about VAD during orientation and onboarding.

Education and refreshers about the legal requirements of VAD as described in the Act and its practical implementation was suggested:

> *"I think we need to know what they use, how it's used, and why that as opposed to that. So okay, what is it? Because people – I even hear some of them go, is it a tablet? People don't know. Right. Is it a lozenge, or is it a drink? So I think there needs to be more education on what it is, how it works, and feel I suppose free to ask a question…… more education on the process." (#2).*
> *"I just think it's one of those things that should be visited annually with a very quick sort of going: just remember these rules." (#4).*

More communication training was perceived as needed. This included training focused on better understanding what people mean when they describe a 'desire for hastened death'.

> *"I think a bit more just education around it and knowing what is a clear request for VAD because someone could say, "Oh, I just want to die," but they don't necessarily mean that. So I think making that more clear and knowing what each person can say because if you say one little thing and it's like, well, that's coercing someone, or that could be considered coercing someone. I think that probably – to make it more clear what is and to make those expectations more clear." (#6).*

Further training in talking with families and understanding family dynamics was also identified.

> *"And I think that that's one of the bigger challenges in hospice anyway is often not the patient, it's the family dynamics. So not just with VAD, but I think with a lot of things it would be good to have a bit of training on how to deal with those dynamics and things like that, and how to speak about that." (#6).*

Some suggested more training in how to support each other including how non-clinical staff could support the nurses, and in non-judgemental regard within the MDT.

There was not a single preferred method for delivery of training with flowcharts, podcasts, lectures, and webinars all mentioned, although role-modelling and on-the-job learning were particularly valued.

Discussion

Two years following the implementation of VAD within this rural, community-owned hospice, this exploration of the day-to-day work, support, education and training needs and gaps responds to Gerson et al.'s call for particular attention on models where PC and VAD co-exist [6].

Those who participated in this study are generally supportive of VAD as a choice for dying people, and for the practice being integrated with PC within the facility. The two key ideas of patient and staff safety and the importance of individual choice and autonomy described in the two earlier papers written prior to implementation of VAD in ACH [11, 12] continue to be reported as significant in supporting integration of VAD into the care delivered. The rural origin of this research is a valuable addition to the literature on VAD in Australia as there have been justifiable concerns expressed about the inequity of access to VAD within geographically dispersed and small communities [14, 15]. The positive experience of providing such care was clearly described. This resonates with work from Canada sharing nurses' description of the relief from suffering by VAD as beautiful and transformational [16] and, despite early fears to the contrary from Australia [17], aligns with a systematic review suggesting no worsening moral distress or anxiety in healthcare practitioners if VAD is delivered in the context of social support for their views and their perceived capacity to offer good care [18].

That integration has occurred successfully in this instance may be due to staff and volunteers receiving support in the workplace regardless of their stance on VAD; having an organisation is attuned and responsive to education and support needs; and workers having confidence that they have the right skills. It is an example of what has been described as the 'thriving care ecology' needed within organisations for successful implementation of VAD practice [19]. The model described here where VAD and PC co-exist is consistent with that recommended by Beuthin and Bruce to leaders within healthcare organisations, highlighting the integration that is possible if focused on shared goals of comfort, quality of life, respect for treatment decisions and delivery of holistic care to patients and families [20].

Despite working in a rural community and within small teams, this study suggests that these staff and volunteers feel well prepared to work with patients choosing VAD, with strong skills in managing boundaries and privacy across relationships and confidence in their ability to provide end-of-life care. Reassuringly, unlike previous papers from Canada [3, 8], the participants report no unusual difficulties about being a rural service, including no undue sense of obligation to participate against conviction. Potential future challenges for the ACH with regards to VAD may occur due to changes in clinical leadership, in the membership of the Board of Management, or in changes in volunteers and staff where there is a decrease in the support to continue with VAD. Equally, although it may have been predicted that VAD may impact negatively on team dynamics within a small organisation, given emerging descriptions of such impact from unrelieved suffering [9] and the concerns of friction and bullying expressed by nurses prior to VAD implementation in Victoria [21], there was no division or polarisation reported within this study.

A novel finding is that survey and interview data show an internal contradiction that was generally not overtly recognised, with the strong reports that VAD had not changed their day-to-day work, contrasting with consistent feedback that the atmosphere in the hospice did change in subtle ways, describing this as a new 'vibe'. This was experienced by all despite varying levels of direct care for patients accessing VAD and volunteer or non-clinical roles. Those supporting or managing such workforce may need to encourage deeper and more reflective conversations to elicit an understanding of this contradiction within a particular facility.

Strengths and limitations

One strength of this work was the involvement of workers from across the MDT and from non-clinical roles providing a wider range of voices to be heard. Previous studies have focused mostly on nurses.

The response rate to the online survey was low however 59 of those on the total distribution list were GPs, many of whom rarely respond to email communication. There was no gender diversity in the interviewees although this does reflect the common female predominance in PC organisations. There were not many voices opposed to VAD resulting in a possible biased description of impact on day-to-day roles and on the perceived challenges of working at the interface. Not all staff had been there before and after VAD implementation so change may have been less obvious to them resulting in a dilution of the described perceived impact. As a study from a small rural organisation there is a potential lack of generalisability to larger organisations.

Conclusion and recommendations

This study has described the experience of day-to-day work of those in a small rural hospice which has integrated VAD into care, observing there are subtle changes in the organisational atmosphere when VAD occurs. The findings highlight the breath of support and education activities valued and the challenge of individual tailoring of these activities to allow reflection, onboarding, refreshers and extension. Including clinical and non-clinical staff and volunteers in education and debriefing sessions around VAD was noted as important. The activities in place and the noted gaps may be a useful checklist for other hospices in the early phases of integrating VAD into their facility.

Recommendations for future research include more purposeful investigation of the impact of VAD on the dynamics of small teams and the longer-term impact on PC workforce and hospice organisational culture including the development of compassion fatigue or change in attitudes over time. It is also recommended that continued support and education are developed for clinical staff as well as non-clinical staff and volunteers to suit individual needs.

Abbreviations

ACH	Albany Community Hospice
GPs	General Practitioners
MAiD	Medical Assistance in Dying
MDT	Multidisciplinary Team
PC	Palliative Care
VAD	Voluntary Assisted Dying
WA	Western Australia

Supplementary Information

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Supplementary Material 1

Supplementary Material 2

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Author contributions
KA, TP and BCB contributed to the concept and design of this work and the acquisition, analysis and interpretation of the data. KA, TP and BCB contributed to the drafting and the critical revision of the paper. KA, TP, and BCB have read and approved the final, submitted version and agree to both be personally accountable for their own contributions and to ensure that questions related to the accuracy or integrity of all parts of the work.

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Data availability
The datasets generated and analysed during the current study are not publicly available due to the small number of Albany Community Hospice staff and volunteers interviewed and the confidential nature of the interviews but are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate
Ethics approval was granted through the University of Western Australia Human Research Ethics Committee (2023/ET000822). This study was performed in accordance with the Declaration of Helsinki and followed relevant guidelines and regulations. All participants provided written informed consent prior to participation.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

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