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Moral uncertainty and distress about voluntary assisted dying prior to legalisation and the implications for post-legalisation practice: a qualitative study of palliative and hospice care providers in Queensland, Australia

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ABSTRACT

Objectives There is little research on moral uncertainties and distress of palliative and hospice care providers (PHCPs) working in jurisdictions anticipating legalising voluntary assisted dying (VAD). This study examines the perception and anticipated concerns of PHCPs in providing VAD in the State of Queensland, Australia prior to legalisation of the practice in 2021. The findings help inform strategies to facilitate training and support the health and well-being of healthcare workers involved in VAD.

Design The study used a qualitative approach to examine and analyse the perception and anticipated concerns of PHCPs regarding challenges of providing assisted dying in Queensland. Fourteen PHCPs were recruited using a purposive sampling strategy to obtain a broad representation of perspectives including work roles, geographical locations and workplace characteristics. Data were collected via one in-depth interview per participant. The transcripts were coded for patterns and themes using an inductive analysis approach following the tradition of Grounded Theory.

Setting The study was conducted in hospital, hospice, community and residential aged care settings in Queensland, Australia. These included public and private facilities, secular and faith-based facilities, and regional/rural and urban facilities.

Participants Interviews were conducted with fourteen PHCPs: 10 nurses and 4 physicians; 11 female and 3 male. The median number of years of palliative care practice was 17, ranging from 2 to 36 years. For inclusion, participants had to be practising palliative and hospice care providers.

Results PHCPs are divided on whether VAD should be considered part of palliative care. Expectations of moral distress and uncertainty about practising VAD were identified in five areas: handling requests, assessing patient capacity, arranging patient transfers and logistical issues, managing unsuccessful attempts, and dealing with team conflicts and stigma.

Conclusions The possibility of having to practise VAD causes moral distress and uncertainty for some PHCPs. Procedural clarity can address some uncertainties; moral and psychological distress, however, remains a source of tension that needs support to ensure ongoing care of both patients and PHCPs. The introduction of VAD post-legalisation may present an occasion for further moral education and development of PHCPs.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ This study investigates the perceptions and anticipated concerns of palliative and hospice care providers (PHCPs) regarding voluntary assisted dying (VAD) in Queensland, in a context of limited research on PHCPs working in jurisdictions prior to legalisation.
⇒ The study used a Grounded Theory qualitative approach through semistructured interviews to gather comprehensive participant perspectives on various issues related to the potential practice of VAD.
⇒ The sampling methodology ensured representation from various institutions and contexts where PHCPs work in Queensland, including religious and non-religious settings, offering valuable insight for policy development in both sectors with the introduction of VAD.
⇒ The participants were self-selected volunteers and may not represent the entire spectrum of the PHCP population in Queensland.

INTRODUCTION

In recent years, ever more jurisdictions have accepted the use of physician-assisted suicide—known in Australia as voluntary assisted dying (VAD)—as an end-of-life option. A 2020 review found 18 jurisdictions worldwide that allow some form of VAD and the practice has consistently increased in countries with long-standing legislation.[1]

International research on palliative and hospice care providers (PHCPs)

participating in VAD-type processes found that the practice was perceived and experienced by many as qualitatively different to other palliative care procedures.[2–4] Although there are reports that the practice of VAD was associated with feelings of professional autonomy and fulfilment,[5] evidence also indicates that VAD continues to evoke intense reactions among care professionals.[6 7] A review of literature on physicians providing VAD found that, among those studies that measured psychological impact, 30%–50% reported emotional burden or discomfort about participation, with 15%–20% describing ongoing adverse impacts.[8] Such evidence demonstrates that the practice of providing VAD is far from a 'normal' procedure and it remains for a substantial proportion of practitioners a challenging experience characterised by moral distress and uncertainties. In the context of VAD, moral distress occurs when a care provider cannot act upon a moral judgement he or she made; moral uncertainty refers to the inability of the provider to choose the right course of action or outcome.[9]

Many existing studies were conducted in contexts where the practice is already underway.[2–6 8] There is relatively little research on perceived distress and uncertainties among PHCPs working in jurisdictions before and anticipating legalisation of the practice. It is unknown whether these PHCPs have concerns like those observed in post-legalisation contexts.

This study aims to fill the gap in the evidence base by exploring perception and anticipated concerns of PHCPs in the State of Queensland in Australia prior to the legalisation of VAD in September 2021. Specifically, it identifies PHCPs' perceptions of challenges they expect to face in their daily work and moral distress or uncertainty they expect to encounter if VAD were available as an end-of-life option. The findings are useful for understanding concerns and needs of palliative care professionals and for identifying resources that help them in providing person-centred end-of-life care after VAD becomes a lawful option in a particular jurisdiction. Insight into how PHCPs perceive challenges before legalisation can also inform strategies to address the ongoing moral distress and uncertainty still apparent in post-legalisation contexts.

VAD in the Australian context

The debate on legalising VAD has a long history in Australia.[10] The Northern Territory was the first jurisdiction to pass such laws in 1995, but the legislation was overturned by the federal parliament 2 years later. Not until 2017 did the State of Victoria pass the VAD Act, which came into effect in 2019. Western Australia passed similar VAD laws in 2019 and so did South Australia and Tasmania in 2021. In December 2022, the federal parliament lifted a 25-year-old ban that stopped the Australian Capital Territory and Northern Territory from making VAD laws. It is likely that these two territories will follow the leads of other Australian states to legalise assisted dying soon.

Queensland is the second largest and the third most populous state in Australia, covering over 22% of the total Australian continent and about 20% of its population. In 2020, the Queensland Parliament conducted an inquiry into VAD and as part of the inquiry, it invited the general public to provide written submissions to express their opinions on this matter. An analysis of the content of these submissions reveals a deep-seated divide in public perception of assisted dying.[11] The inquiry report published by the government recommended the practice be legalised.[12] The Queensland Law Reform Commission then prepared a draft legislation, which was passed in September 2021.[13] The VAD Act 2021 has come into force on 1 January 2023.

METHODS

This study investigates the concerns of PHCPs about providing VAD, before the legalisation of VAD in Queensland with data collection conducted from November 2020 to March 2021. PHCPs are defined as doctors and nurses who have direct involvement in the provision of end-of-life care in their daily work. The study adopts a qualitative design with an interpretive approach appropriate for illuminating meaning and capturing different perspectives on complex healthcare issues.[14] Data were gathered via semistructured in-depth interviews, which are flexible, dynamic and sensitive to the social context.

Recruitment of participants

Recruitment was conducted between November 2020 and February 2021 using a purposive sampling strategy to include a broad representation of perspectives. The study was promoted in the newsletters of the Centre for Palliative Care Research & Education and Palliative Care Nurses Australia. Information sheets were also sent to all hospices and palliative care services on the website of Palliative Care Queensland. Several participants with rich information and experiences were recruited via the researchers' prior professional contacts.

Data collection

Data were collected via one in-depth interview per participant that lasted for 45–60 min. The researchers used an interview guide to elicit discussion regarding participants' experiences of handling end-of-life requests and potential challenges they may encounter if VAD were legalised in Queensland. The participants could direct and shape the discussion in line with their concerns. The interviews were conducted online using the Zoom platform. All interviews were recorded with consent. A self-administered form was employed to collect demographic information and work experience before the interview. The interview guide and self-administered form are available for download as online supplemental files 1 and 2.

Data analysis

All interviews were transcribed verbatim using the automated transcription service provided by Zoom and

checked for errors by a research assistant. The transcripts were read and coded repeatedly for patterns, categories and themes in NVivo V.12 using a Grounded Theory approach.[15] Each transcript was read several times to achieve data immersion. The method of open coding was used to organise and sort the data into categories and patterns for interpretation. The analytical themes identified were fed back in the subsequent coding process and refined in a progressive manner.[15] The inductive analysis reached a saturation point at the 11th participant. Three more interviews were conducted to make sure that no concerns of the PHCPs in Queensland were overlooked.

Rigour of analysis

The three researchers designed the study and interview guide together. C-WL conducted the interview and undertook the preliminary analysis. The transcripts were iteratively coded with emerging categories and interpretations refined in comparison with data collected from subsequent interviews.[15] DGK and AH checked the coding and sets of themes identified. The research team continued with this process of coding and discussions until it arrived at a final set of themes and interpretation.

Findings are reported in accordance with the Standards for Reporting Qualitative Research Guidelines. To maintain confidentiality, identifying data has been anonymised and work setting and characteristics of an individual are only reported if the information does not reveal the identity of that participant.

Patient and public involvement

Patients or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

Reflexive statement

All three authors are academic researchers from non-clinical backgrounds. DGK is a theological ethicist specialised in biomedical and social ethics and the ideas of human dignity and autonomy. C-WL is a public health sociologist with research interests in social determinants of health and experiences of people living with chronic illnesses. AH is a bioethicist and health services researcher with a particular interest in social justice issues arising in healthcare. This research is based in the Queensland Bioethics Centre (QBC) at the Australian Catholic University and two of the authors, DGK and C-WL, are researchers at QBC.

The study does not reflect the Catholic Church's position on VAD and euthanasia. To ensure a broad representation of perspectives was captured, the researchers purposively recruited participants from both secular and faith-based institutions. The researchers are also aware that the association of the study with a Catholic university might have affected participants' willingness to talk openly about their experiences, or this knowledge might have shaped what was said in the interview. To minimalise this impact, the interviewer (C-WL) reminded every participant at the beginning of the interview that this study is not about for or against VAD or taking a Catholic perspective on the matter. Attention has also been paid in the processes of interpretation and writing up of the manuscript that opinions of the participants are analysed and reported in a balanced and unbiased manner.

RESULTS

Participants articulated their experience with requests to actively end life, their perception on the relation of VAD to palliative care and how legal changes may affect their daily work. Their viewpoints are summarised below in four overarching themes: VAD as a form of palliative care, perceived moral challenges and conflicts at work, anxiety and emotional distress, training needs and support.

Characteristics of participants

Fourteen PHCPs participated in the study: 10 nurses and 4 physicians (table 1). The median number of years of palliative care practice was 17, ranging from 2 to 36 years. Participants worked in various palliative care settings, including hospice, residential care, home and community care, and palliative care units in a hospital, with one participant working in multiple settings. Six worked in a secular institution and seven in a faith-based institution. One worked across these two settings.

Relationship between VAD and palliative care

VAD as distinct from palliative care

The participants were divided in their perception of VAD as an end-of-life option. Eight (all four physicians and four of the nurses) rejected the practice as a form of palliative care as they believed VAD has nothing to do with relieving suffering or improving quality of life of the patient. Accessing VAD, as PW4 (a hospital physician) explained, may 'prevent someone from accessing palliative care and then being able to do things like planning for the future or supporting their family.' Other participants insisted palliative care was not to hasten death or intentionally end a life. There was also a fear that linking VAD and palliative care may reinforce long existing stereotypes that equate palliative care with euthanasia or 'the palliative care doctor will come with a big syringe and kill my father, things like that' (PW6, a community nurse).

VAD as part of palliative care

Six participants perceived some continuity between VAD and palliative care. They considered VAD as an additional tool or another possible result of end-of-life care and this is the responsibility of a palliative care practitioner 'to care for everybody and how they die at the end whether they choose that path [VAD] to go down, that's just another mechanism of them actually dying' (PW13, a hospice nurse). For participants holding this view, VAD fits into palliative care and the provision of it demonstrates a person-centred approach that cherishes choice and dignity of the patients.

Table 1 Participant characteristics

Characteristics	Number of participants (n=14)
Gender	
Male	3
Female	11
Role in palliative care	
Nurse	10
Physician	4
Years of experience	
<10	4
10–20	6
>20	4
Place of work	
Hospice	3
Residential care	1
Home and community care	5
Hospital	4
Mixed	1
Geographical location	
Urban	9
Regional/rural	5
Workplace environment	
Secular	6
Faith based	7
Mixed	1
Nature of organisation	
Public	5
Private	3
Mixed	6

Reasons not to participate in VAD

Despite their disagreement on VAD as a form of care, most participants indicated they would not want to participate in assessment of eligibility and/or provision of drugs were it to become legal in Queensland: of the 14 participants, only 2 indicated that they are willing to participate in these practices, 10 said they would not be involved with 2 remaining undecided. Many agreed VAD should be implemented by a separate or special team. Perception of role incompatibility or conflict was the most common reason given for not participating for those who conceived VAD and palliative care as incompatible:

> I don't think I should, as a palliative care nurse, do that, full stop … palliative care nurses as such in the palliative care setting, shouldn't be in that position where they assess the patient. No way. (PW6, a community nurse)

Lack of skills and knowledge of making VAD assessment/decision, feeling uncomfortable, fear of legal risk or stigma were other reasons put forward by the participants to explain their decision not to practise VAD.

Perceived challenges and moral conflicts at work

Participants anticipated that legalisation of VAD would have a profound impact on palliative care. But when asked to what extent this change in legislation may affect their daily work and responsibility, many described the impact or change as minimal in their initial response to the question. Such a response is common among participants who said they would not participate in VAD or that the institution they worked in will have opted out of the practice if it becomes legal:

> … our hospitals are Catholic hospitals, and it will be made quite clear that VAD will not, does not happen in this hospital. Even if it did, I would be a conscientious objector … it would not affect my practice. (PW3, a hospital physician)

But as the interview went on, many participants showed awareness of and expressed concerns about various uncertainties or distress that VAD may bring into their work. As PW7 (a community nurse), who is working in a faith-based organisation that will opt out of the practice of VAD, remarked: 'How do you deal with it as a palliative care service if you're not involved in it, but you're kind of forced to be almost?'

The uncertainties and moral distress the participants reported during the interview fall into five domains:

Handling requests or conversations

Participants expected an increase in requests to discuss VAD should it become legal in Queensland. Many believed they should not avoid the topic or 'refuse to talk about anything the patient wants to talk about or at least hear them and be sympathetic' (PW8, a community nurse). Many expressed doubts and concerns about how to handle such a conversation properly: should they steer the talk into a palliative care scenario, or should they refer the patient to someone else? The matter became even more complicated when one considered the restrictions imposed by some VAD laws on initiating conversations with patients. As PW4 (a hospital physician) explained the challenges involved:

> How do you explore that in a way that doesn't implicate you because you're not allowed to say about VAD first? So how do you explore someone's desire for death without implicating yourself by bringing it up because then you can be, I think you can be convicted or fined in any way for being the person who brings it up first with the patient.

Assessing patient capacity

Participants were uncertain about evaluating the ability of the patient to make a VAD request or choice. Not only was

this assessment complicated and controversial, but the results may also be challenged by the family or relatives at a later stage:

> … in the same way many people challenge [a] will [based on mental] capacity after someone died, some relative could say, you know they were actually confused and stuff happening. So, I think that the stakes are so high when you're talking about voluntary assisted dying… I think that's a very scary thing to me. (PW4, a hospital physician)

There was also a concern about the ability of the patient to complete VAD and how this may implicate the palliative care worker in a VAD attempt. As PW9 (a hospital nurse) observed:

> My dilemma is that they have capacity when they initiate but then if they deteriorate quickly, then what happens if the process [request access to VAD medication] is almost complete and they are not capable of doing it for themselves, then what happens? Will someone intervene or the process just finishes. That bothers me a bit that someone may feel obligated.

Arranging patient transfer and logistical issues

Participants were very worried about issues related to continuity of care that might arise because of a VAD request. For example, PW7 (a community nurse) outlined a concern as someone who carries out palliative care in a community setting: 'What do we do if a patient has gone through with VAD [application/assessment], who is a community palliative care patient? Are they still a community palliative care patient?' Many participants expressed a similar sentiment, namely, once a person chooses VAD, do they stop being a palliative care patient?

A related concern arises from the potential need to refer or transfer patients out of the present facility if it does not offer VAD for religious or logistical reasons. Besides wondering who they should refer the patient on to, the participants also expressed deep concern about the lack of continuity of care, which they would view as a professional failure as a palliative care specialist. PW1 (a hospice nurse) with more than 15 years of experience explained:

> … it's not just the occupancy and the statistical things that would change, it would impact us professionally as healthcare workers, where you start to question, have you failed that person, have you provided them with enough information.

Participants were also uncertain about how and where VAD would take place and the logistical arrangements required to ensure a safe VAD programme:

> If this had happened in hospital, I mean, do you need a separate ward? It would be abhorrent to think that it would be undertaken in a four-bed ward, for instance. You know, how would it work practically? What about junior staff? Are junior staff obliged to look after people who are being euthanised? (PW3, a hospital physician)

Managing unsuccessful VAD attempts

A few participants pointed out that, like all medical procedures, there is a possible risk that the VAD attempt may fail, and this will leave the palliative care worker in a very delicate situation: 'You know, what happens then? Do you look after those patients? Do they go to ICU [intensive care unit]? …. Do you just leave them at home to suffer?' (PW3, a hospital physician) Or, what if the patient 'ends up with some complication where they are no longer able to even give consent to [another VAD attempt]?' (PW2, a hospital physician). Facing such problems in the workplace, as PW8 (a community nurse) admitted, will be 'really distressing for everyone concerned and then I guess we would be involved in some way looking after that person [after the unsuccessful attempt]'.

Dealing with team conflict and stigma

Participants perceived VAD as a controversial issue, and many were worried about possible resulting individual and/or team conflicts:

> … there would be conflicts between professionals, you know, those who did and those who didn't. We all work in teams and the thought that some members of your team would be involved in this and some were not, it would be I can imagine great inter-professional conflict. (PW3, a hospital physician)

Given VAD is a matter loaded with deep-rooted personal, moral and religious views, participants were worried that the usual conflict resolution strategies will be ineffective in resolving these differences or clashes. Appeals to allegedly scientific evidence may also prove futile. As one participant observed, 'We'll be asking somebody to change their moral framework, their ethical framework or doing something that might contradict that, and so I suspect that would be very difficult' (PW13, a hospice nurse).

Some participants also reported their fear of social stigma surrounding those healthcare workers supporting voluntary assisted dying or the special team which will handle most of the VAD cases. These individuals or teams were at greater risk of being labelled as 'pariahs or Dr Death or something like that' (PW14, a community nurse) and isolated.

Anxiety and emotional distress

The prospect of engaging in VAD practice has taken a personal toll on the participants. Some described the experience of anxiety and struggle in making sense of the practice. As PW1 (a hospice nurse) observed:

> I know that it's something that I'll take home with me and think about a lot because essentially it's similar to someone practising suicide, and although I don't

make judgements, I think I will always question if I failed as a nurse in caring for that person… I think I would genuinely struggle if it does come to pass and our facility facilitates that where I have to be involved.

PW11 (a residential nurse) was concerned about the psychological burden and emotional impact on healthcare workers of practising VAD:

This is dangerous work, mentally and in our hearts and people think by going with the right intention I'm doing this to relieve people's suffering. Well, that may be the first time, but the tenth time it starts, you start to feel a burden, like never before.

Concerns about emotional distress associated with the practice of VAD extended beyond those healthcare workers who directly provide the service. Participants worried that the death of a patient choosing VAD will also affect other professionals involved in the care of this patient. As PW7 (a community nurse) explained:

… if they have a patient who is on the palliative care service that chooses this, [it] is going to [have] hugely emotional impact on the clinicians having to deal with this. I think if a patient goes through with it and they do it at home under a palliative care service I think that's going to be really hard…. It can be quite … it might be quite traumatic.

Training needs and support

Participants believed they were not prepared for the coming of VAD in Queensland. Some admitted they have not thought through or discussed the issue with their colleagues. PW5 (a hospice physician) explained the difficulties involved:

The majority [of healthcare care workers] will be less clear in their own minds about what approach to take until the legislation is through, until it's clear what's being asked of palliative care physicians working with other clinicians. It's quite difficult for people to be able to articulate exactly what their position is.

Participants agreed a lot of work needed to be done to prepare them for the challenges of VAD coming into Queensland. They highlighted areas where training and education are required. Top of the list was the need for information on the framework, structure and regulations of VAD practice. Participants wanted to clearly understand the process, pathway and their responsibility in VAD in Queensland.

Another area of training highlighted by the participants was the need for additional communication and assessment skill training that target VAD requests and dealing with the families on this matter. Participants suggested training for VAD be part of continuing education and training provision.

A few participants also stressed the need for further funding and support for basic palliative care training in Queensland, highlighting the inadequacy of training in palliative care:

They certainly don't have enough training in palliative care. I used to train the medical students at [a local university]. They used to get four hours of palliative care training in their career. Now, I don't think they get any! How is it fair if they ever did get training in euthanasia but never get training in palliative care and end-of-life care? (PW3, a hospital physician)

Besides the need for information, guidelines and clinical skills, participants also emphasised the importance of resilience training and support to deal with the emotional and spiritual impacts of VAD, especially for those healthcare workers directly involved in the provision of the service. Many praised the value of a team or peer approach and collegial support in maintaining and improving psychological well-being of palliative care workers. But PW12 (a hospital nurse) was worried that such support networks are difficult to cultivate in VAD practice: 'You have to work in teams. In some ways, it's the complete opposite of the approach of the VAD, which will come out, which will be not being able to deal with helplessness and not dealing in a team.'

DISCUSSION

This study interviewed 14 PHCPs in Queensland to investigate their perception of VAD practice and possible challenges, uncertainties and moral distress prior to the legalisation of this practice in this jurisdiction.

In line with findings of previous research on PHCPs in Belgium[5] and Canada,[2 3 6] where assisted suicide was already legal, this study in Queensland found that many PHCPs did not think VAD should be part of palliative care. Regardless of their view on the relationship between VAD and palliative care, there was a general reluctance among the participants to provide VAD. Yet, these expectations of staying away from the practice may be unrealistic. While PHCPs in Queensland may not have to actively provide VAD, they likely cannot avoid anything to do with the practice given the complexities of transfer and logistical arrangements as reported above.

Although the lack of information and direct experience might make the challenges look less 'personal' to some participants at first sight, most associated the practice of VAD with moral uncertainties, tensions and distress. They worried that once VAD is legalised in Queensland, it would create new practical, professional and moral challenges to their daily work, whether they are directly involved in its implementation or not. So, given that complete avoidance of VAD is unlikely, education and support to relieve the moral distress and uncertainty identified in the study are necessary, and need to go beyond simple procedural measures.

Participants identified five domains of concerns: handling requests, assessing patient capacity, arranging patient transfers and logistical issues, managing

unsuccessful attempts, and dealing with team conflicts and stigma. Similar concerns have also been identified in recent studies in North America[4 16] and systematic reviews on PHCPs providing VAD.[8 17] Findings of this study have highlighted and elaborated in specific details the worries around assessing patient capacity, arranging patient transfer and logistical issues, and managing unsuccessful VAD attempts.

Participants of this study felt uncertainty and distress at having to face these challenges at work. Some of the concern came from the uncertainty about exactly how the law would operate and what procedures would need to be followed. This is to be expected in a pre-legalisation context. In post-legalisation contexts, where many of these rules are clear and procedures are in place, the uncertainty has been alleviated. For example, the Queensland VAD Act, which was passed after data collection of this study was completed, does not prohibit PHCPs from initiating conversations about VAD, and so alleviates the uncertainty expressed by PW4 related to handling requests.

Other distresses the participants described, however, were linked to value conflicts or institutional constraints that might prevent them from following what they believe to be the morally right course.[9] Participants were worried that the legalisation of VAD may alter the nature of care they provided or the relationship with the patients they cherished—that they must terminate care and transfer the patient elsewhere or deny the patients the opportunity to experience all palliative care options available. This fear of failing the patient or breaching the personal duty of care and/or core principles of palliative care remains an important source of distress for many participants in this study. Similar concerns or anxieties were also reported in studies conducted in contexts where VAD is already underway.[5–7 17] The persistence of these worries and fear post-legislation indicates that such concerns will not disappear with time or be alleviated by clearly written laws or practice guidelines.

Opposition to VAD is often associated with religious world views, but recent studies on factors influencing participation in assisted dying reveal that a simple dichotomy between religious opposition versus secular support is overly simplistic and not representative of PHCPs' concerns.[7 18 19] Our findings highlighted a range of practical or personal considerations not directly linked to religious convictions, such as lack of professional competence/knowledge and negative emotions or fear of legal risk and stigma as reasons for non-participation in provision of VAD. Also, this was distinct from whether or not they supported the practice in principle. The practical realities and moral complexities of concrete situations will make it difficult in practice for PHCPs to reduce the question of participation in VAD to a simple yes/no matter. Even for those working in faith-based institutions, which would be expected to object to VAD on their premises, PHCPs may continue to encounter situations where their moral or professional convictions will be challenged.

This study has several limitations. The participants were self-selected volunteers and this may be a source of bias. A related limitation is that the sample of nurses and physicians may not represent the entire spectrum of the PHCP population in Queensland and this restricts the generalisability of the findings from the study. Finally, this study collected data only at the time prior to VAD legislation in Queensland. Given assisted dying is a rapidly developing topic, we recommend follow-up or comparative research to track changes in the needs of PHCPs and their perception of the practice over time.

CONCLUSIONS AND POLICY IMPLICATIONS

This study revealed that PHCPs in Queensland are divided in their perception of VAD and the prospect of engaging in such practice is a cause of anxiety. That similar challenges had also been reported by PHCPs working in jurisdictions that legalised VAD[2–6 8 16 17] indicates that legislation and procedural regulation alone will not solve all these problems. There is a need to address them through multifaceted support to palliative and hospice care professionals. Findings of this study, especially those on perception of training needs and support, help pinpoint important areas where action and intervention are most needed.

In terms of resources and support:

- Clear clinical guidelines, and legal and policy frameworks should be provided and explained to organisations and care providers.
- Given the likelihood that PHCPs will encounter VAD even if they do not want to participate, PHCPs should be provided with access to ongoing training on communication and assessment skills related to VAD, regardless of their willingness to be involved. This will facilitate communication not only with patients but also with other practitioners, including those actively involved in VAD.
- Given the potential impacts of VAD on psychological well-being of PHCPs, including those who implement VAD, these workers should be provided with mental and emotional health support via peer-based networks and/or professional services.

Although clinical guidelines, skills and logistical support can help reduce uncertainties associated with VAD, they are unlikely to resolve moral distress that results from fundamental value conflicts or constraints. Given the strong normative valence associated with assisted dying, VAD will remain a contested concept that continues to arouse uncertainties and distress among PHCPs. As Charlie Kurth[20] has succinctly argued, the feeling of moral anxiety is not only an adverse emotional response but also a motivator for ethical deliberation and critical reflection, which are quintessential for moral agency and integrity. Moral distress around VAD thus might be a good thing for society, as it opens up an opportunity for ethical reflection and development at both the individual and organisational level.

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Patient and public involvement Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

Patient consent for publication Not required.

Ethics approval This study involves human participants and was approved by the Australian Catholic University Human Research Ethics Committee (ref. 2019-108H). Written informed consent was obtained from the participants before the interview.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data are available upon reasonable request. The semistructured interview guide and the self-administered form for the collection of demographic information and work experience are available on request from the corresponding author. The data are not publicly available due to them containing information that could compromise research participant privacy/consent. Please contact the corresponding author if you have questions about the availability of the materials.

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