General practitioners' experiences of voluntary assisted dying in Queensland

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This article is part of a series of articles on voluntary assisted dying.

Background and objective
Voluntary assisted dying (VAD) is lawful in all Australian states, and doctors are an integral part of the VAD process. There are limited reports so far on general practitioners' (GPs') experiences with VAD. This study explores GPs' perspectives on the first year of VAD in Queensland and any factors that influence choices on whether to participate in VAD.

Methods
This was a qualitative interview study of 12 GPs with no in-principle objection to VAD, undertaken 1 year after VAD became available in Queensland.

Results
Thematic analysis identified four themes: nature of GPs' participation, various factors influencing participation, experience of GPs with VAD provision and the ongoing needs of GPs.

Discussion
This study highlights how GPs are well suited to VAD provision with their generalist approach to care. However, there are ongoing structural and logistical barriers to GP participation, including the need for appropriate remuneration and further education on VAD to support GP knowledge.

VOLUNTARY ASSISTED DYING (VAD) is lawful across all Australian states and in the Australian Capital Territory. Doctors are an integral part of the VAD process and required for patient access to VAD. Training and specific qualifications are needed for those doctors choosing to become VAD practitioners in each jurisdiction.

The uptake of doctors, including general practitioners (GPs), choosing to participate in VAD varies across states. Assessing the extent of GP involvement in the VAD process is challenging because of variation in reporting across different states. However, it is reported in Victoria that 59% of authorised practitioners are GPs, and they comprise 71% of those providing VAD in regional and rural areas.[1] In Western Australia (WA), GPs make up 46% of participating practitioners;[2] in Tasmania, GPs represent 60% of doctors who completed training and 72% of the doctors who participated in VAD in 2023/24.[3] The proportion of GPs choosing to participate in VAD is important as they are the primary carers of patients and often closely involved in their end-of-life care.

There are multiple reasons for variation in participation in VAD, with the experiences of those participating in Australia reported to include a significant time requirement, unclear remuneration, and emotional and ethical considerations.[4–7] Of particular impact for GPs is the lack of direct Medicare rebate for VAD[4,8] in addition to the considerable time requirement. The way in which VAD systems are structured can also affect participation of doctors, including GPs. For instance, Queensland has a unique VAD system where 90% of cases are provided through the public system.[9]

There are limited reports on GPs' experiences with VAD and the direct factors that may influence their participation. This study explores GPs' perspectives 1 year after the VAD law came into effect in Queensland. It considers their perspectives on the first year of VAD in Queensland and factors that influence choices on whether, and how, to participate in VAD.

Methods

This paper reports on semi-structured interviews conducted with 12 GPs after VAD had been in operation for 1 year. This is a subset of 27 doctors who are part of a wider longitudinal qualitative study exploring perceptions of VAD in Queensland before and after the law began.

Participants in the wider study were doctors in Queensland who had no in-principle objection to VAD and met the criteria to become VAD practitioners. Initial participant recruitment included study information on social media, such as The Royal Australian College of General Practitioners' Facebook page; medical societies; hospital and health service

networks; and snowballing. Purposive recruitment was used to capture a range of urban, regional and rural representation. Initial recruitment ceased once information redundancy (saturation) was reached. There were 14 GPs in the initial set of interviews (before the law began), and two declined to participate in this second set of interviews. The 12 participants included in this paper met the eligibility criteria of a primary specialty of general practice and agreeing to be interviewed again, this time after the law had been in operation for 1 year; no additional recruitment was needed for this second set of interviews.

These semi-structured interviews were conducted by LLG from January to April 2024. The interview guide was developed within the research team, who have expertise in VAD. Open-ended questions explored participants' experiences with VAD. All interviews were recorded as Zoom conferences. Interviews lasted between 14 and 74 minutes (average of 40 minutes). The interviews were transcribed, de-identified and sent to participants for member checking and approval.

LLG used Braun and Clarke's reflective thematic analysis[10] to code the data line by line using a constructivist approach. The approach to coding was both deductive and inductive to allow for all topics raised to be coded. Both semantic (descriptive) and latent (interpretive) content was coded for. Preliminary coding was discussed with all authors, and subsequent development of themes was tested by all authors. NVivo 1.6.1 (QSR International) was used to store, code and organise the data.

This study was approved by Queensland University of Technology Human Research Ethics Committee: 2022/5020 and Royal Brisbane and Women's Hospital (RBWH) Queensland Health Human Research Ethics Committee: HREC/2022/QRBW/86914. All participants provided informed consent prior to the interview.

Results

The demographics of the 12 participants included in this analysis, whose primary specialty was general practice, are in Table 1. Thematic analysis identified four themes: nature of GPs' participation; factors that influenced participation; experiences of GPs with VAD provision; and ongoing needs of GPs. Quotes supporting each theme can be found in Table 2.

Nature of GPs' participation

Although all GPs had no in-principle objection to VAD, they had varying degrees of involvement with VAD during the first year in Queensland. Eight GPs successfully became authorised VAD practitioners, and seven of those participated in at least one case of VAD. Four of these GPs had been involved with over 10 cases of VAD, and two with over 50 cases each. Four GPs did not become authorised practitioners or participate in VAD.

The nature of participation also varied. One practitioner chose only to participate as the 'consulting practitioner': the second doctor whose only role is conducting an eligibility assessment. The other six participated in this consulting practitioner role as well as acting as the 'coordinating practitioner'. The coordinating practitioner is the doctor who has the overall responsibility for the process, including the eligibility assessment and writing the VAD prescription. Three of these participating seven GPs had also taken on the role of administering practitioner, where they administered the VAD medication to at least one patient.

There were also varying ways in which GPs' participation took place. Three GPs had designated workload time through a Queensland Health appointment to participate in VAD, with varying full-time equivalent fractions. One GP participated as part of their existing employment with Queensland Health within the hours of their existing non-VAD role (without a designated VAD workload). One GP participated as part of their usual general practice. Finally, two GPs participated in addition to their existing roles, outside of their usual general practice.

Factors that influenced participation

There were various factors influencing GPs' participation in VAD. The first set of factors relates to the process of becoming authorised to provide VAD. Some GPs, both those who successfully became authorised practitioners and those who did not, reported the initial application process was arduous, requiring specific paperwork and references. Further, the legally mandated training was also prohibitive for some, as it took a long time to complete, was difficult to pass and was frequently unremunerated.

Secondly, the distinctive VAD system design in Queensland influenced the degree of participation of many GPs. VAD participation in Queensland is predominantly through those employed for VAD in the public system and Queensland Health. This limits participation by GPs in the community. Some GPs in the community were happy to participate for their patients or those who

Table 1. Participant demographics

Demographic	Number of participants
Gender	
Male	7
Female	5
Age range (years)	
20–29	1
30–39	2
40–49	6
50–59	2
60–69	0
70–79	1
Geographical area	
Urban (Greater Brisbane)	2
Regional	7
Rural	3
Specialty college	
The Royal Australian College of General Practitioners	7
Australian College of Rural and Remote Medicine	5
Length of practice (years)	
0–10	2
11–20	4
21–30	4
31–40	1
41–50	1

were referred to them, although some felt they have not been required to participate yet, or as much as they expected, because of this public system design.

Thirdly, non-participation or less-than-expected participation for community GPs was influenced by the lack of clear remuneration and a specific Medicare rebate for VAD participation. In addition, in some areas of Queensland, GPs were funded to complete the VAD training or participate in the process by their local public health service. The lack of funding for GPs in certain areas led to feelings of disparity between regions, depending on the level of support offered by individual health services. The time required for participation in each part of the VAD process coupled with the lack of clear remuneration was influential in participation decisions for some participants.

Finally, for some GPs, there were practice considerations that affected their participation. This included the need for practices to allow VAD participation on their premises and allow the billing of VAD through the practice.

Experiences of GPs with VAD provision

GPs who participated in VAD reported that general practice was well suited to VAD provision. General practice is generalist in nature and facilitates the provision of holistic care, which is needed by many going through the VAD process. GPs also routinely provide mental health support and ongoing symptom management with a patient-centred care approach.

Others described providing VAD as a continuation of care for their patients. Some GPs described how VAD became part of their end-of-life care process, including doing home visits for parts of the VAD process as an extension of the end-of-life care they already provide. For these GPs, remuneration and billing were easier as it was part of their existing end-of-life care. For others, the VAD process was completed in long appointments, and the required paperwork was absorbed into their usual paperwork time.

Some GPs considered participating in VAD as the coordinating or administering practitioner was more difficult if they had a long-standing relationship with the patient. Some found participating as the consulting practitioner was easier. This only involved an eligibility assessment, so they were less involved in the process and did not have to write a VAD prescription.

There was concern expressed by some GPs about the correct completion of the forms associated with the VAD process. Although this became easier over time and with repetition, where participation in VAD was infrequent, there were concerns about a lack of expertise and possible resulting errors in the paperwork.

Table 2. Quotes supporting each theme

Theme: Nature of GPs' participation	
Nature of participation	'Practically none is the answer. So although I was one of the first doctors, I think to do the training, become an authorised prescriber, (I've) not really anything to do with VAD.' (P2) 'I have been both a consulting practitioner, a coordinating practitioner, and an administrating practitioner in the last 12 months.' (P18)
VAD workload	'It has been manageable because I basically just do it and claim it as work hours within my health service and I've never had an issue doing that.' (P18) 'I'm probably working about double what I'm employed in. And so some of that time pushes into my substantive rural generalist time and my local hospital. And some of that time pushes into my personal time.' (P3)
Theme: Factors that influenced participation	
Application to become an authorised VAD practitioner	'So I actually considered becoming a provider or part of the process myself, but it was quite onerous to actually join up. So even things like wanting my degree certificates and all sorts of things, which are probably somewhere in boxes somewhere, but it wasn't enough that I'm registered with AHPRA or that I'm a current member of the RACGP. That wasn't good enough. I had to go back and get quite a lot of historical certificates, which is, it's just not super inviting to have to get on board with all that.' (P6) 'I think when you are already busy, if there were enough barriers to taking on a new role, it becomes, it just doesn't reach the threshold of jumping into it, unfortunately. Yeah, even if you believe in it.' (P6)
Queensland VAD system	'The (local VAD) community, know we are available, we are around. But we haven't really put our hands up to take on extra yet other than our patient share.' (P12) 'It's concentrated in very few hands and the ability of someone like me to get any cases pretty, much zero. Because I didn't walk through the door at the right time.' (P17)
Remuneration	'Not necessarily having additional funding to provide this and working out how we provide that within our current footprint was challenging at times.' (P8) 'It needs to be funded to ensure the longevity, you can't (keep hoping) that private practices will provide the service when there's no Medicare billing numbers for it. And people feel terrible about charging people for the consults, the massive gap.' (P3) 'Unless you have funding through your PHN or the state, which I think some areas do, if you provide the care yourself, you can't do it on a bulk billed measure unless you're literally doing it as a charitable.' (P6) 'My first couple of patients have no concerns with just billing it like they normally do, even though I would often bulk bill a lot of my palliative care patients towards the end.' (P12)

Table continued on the next page.

Table 2. Quotes supporting each theme (cont'd)

Theme: Experiences of GPs with VAD provision	
Holistic care provided by a generalist approach	'I would still imagine that a lot of the practitioners who are registered are still going to be general practitioners or palliative care or related fields. Just because contact with patients who are dying and the value and the knowledge of that holistic longitudinal care is really important.' (P15) 'One lady who's actually has got the substance ready to use, I thought she was depressed. So I gave her some antidepressants and she actually picked up and said, "Oh, I may not need to use this stuff." Because she's got a terminal illness, so she's eligible to get it. But she said, I may not need it, may not need to use it. So I thought that's good. There's no coercion, no need to have to use it.' (P4)
Providing for known patients	'I think from a personal point of view, this would likely be a lot more challenging when you're providing a service to someone that you've managed to create a relationship with for many, many years, regardless of how you feel about VAD in general because you are taking someone's life and it's the life of that person that you have tried to preserve for as long as possible.' (P27)
Complexity in the process	'Forms are a bit cumbersome at the beginning, once you get used to them, once you've done them a few times, just it's a very straightforward process I think.' (P27)
Theme: Ongoing needs of GPs	
Need for education	'There is definitely still a lack of understanding and education amongst the other doctors, particularly more junior doctors, the general belief is that they can't raise it with people. That they're breaking the law if they tell somebody that this is something that they can look into, that's definitely an ongoing theme.' (P18) 'One of the challenges was that just making sure that people knew that even non-doctors that knew that this was an option for patients and that we have to provide it.' (P8) 'We still get a lot of reports from people that approach their GP seeking information or seeking assistance. They have just been knocked back with complete disregard for their obligations just by saying: "look, I don't know anything about that. I'm not interested." Or "we don't do this here, find that information somewhere else."' (P27) 'I don't feel in general GP community, it's that well realised that it's there. I think that is probably something that needs addressed.' (P2)
Raising VAD	'(Raising VAD) has gotten easier. The first time I did it was so funny. It's so awkward. You go, you don't know how to say it. You're like, oh, what do you reckon about dying yourself? It's very weird. And it gets easier. And I've actually found that it's less awkward than you think it's going to be.' (P3) 'I do (raise VAD). Not every patient obviously, but certainly ones where I feel it is appropriate to do so. And I do very much agree with the rule, the law that you need to do that as part of a discussion of all of their options. And so again, you kind of get these standard spiels I suppose.' (P18) 'There is a lack of knowledge, lack of it being brought up with people, unless there's someone that's passionate about it and you can't rely on that, we need something more.' (P2)

AHPRA, Australian Health Practitioner Regulation Agency; GP, general practitioner; P, participant; PHN, Primary Health Network; RACGP; The Royal Australian College of General Practitioners; VAD, voluntary assisted dying.

Ongoing needs of GPs

Participants identified some ongoing needs of GPs regarding VAD. There were requests for additional education because of an ongoing misunderstanding of what VAD is, which patients may be eligible and the VAD process. Some participants reported those working within Queensland Health had a better understanding of this. Nevertheless, participants identified a need for ongoing education for those practising in the community, particularly those based more rurally and newer GPs.

GPs also called for guidance for how to discuss VAD as an option with patients. This included the ability to discuss all end-of-life options and raise VAD in appropriate situations, as well as discussing the VAD process steps. Some GPs were comfortable raising VAD and did so as part of usual discussions on end-of-life care. For others who had not yet had this opportunity, they wanted clearer guidance on how to do so. Support to discuss ineligibility for VAD was also perceived as important to provide continued care for patients and discuss their other options.

Participants reported there was a lack of understanding in the general public regarding VAD, including conflating VAD with palliative care. There were requests for more public discussions about end of life generally as well as further community education on VAD to improve this.

Discussion

This study provides an overview of 12 GPs' experiences of VAD during the first year it was legal in Queensland. Participants reported variation in the nature and frequency of their participation in VAD, ranging from no participation to a significant (>50) case load. This study helps identify barriers to participation in VAD including the application process to become an authorised practitioner; the structure of VAD services in Queensland; the acceptance of VAD by individual general practices; and the lack of remuneration. GPs who did participate in VAD highlighted how GPs were well suited to VAD provision because of their generalist specialty and how it could enhance continuity of care for some patients. They identified, however, a need for further support for GP education on VAD and how best to incorporate this into practice.

GPs were perceived to be well suited to VAD provision because of their holistic, patient-centred care. As the primary medical carers for patients, GPs are likely the first point of call for many patients when discussing end-of-life care[11–13] and therefore also the possibility of VAD. GP involvement in end-of-life care is known to be valuable for patients[14,15] and rewarding for practitioners.[16] In countries where VAD is an established medical practice, such as the Netherlands, GPs are regularly involved in patient discussions and the VAD process.[17,18] It is possible that as VAD becomes more established in Australia and public knowledge of the option increases, GPs will be called on more often in relation to VAD and will need to be appropriately supported. This study helps identify areas needing attention for this to happen, including adequate education for all GPs and appropriate support for those who wish to participate in VAD through their general practice.

GP involvement in VAD in Queensland is varied, with challenges to participation including structural constraints, logistical barriers and ongoing support needs. Broad structural constraints include the structure of VAD provision as a public medical service in Queensland instead of through GPs in the community.[9] Although some GPs held fractional time within Queensland Health to provide VAD, the number of positions is limited, and it is not possible for all willing GPs to participate in this way.[19]

Another structural constraint challenging GP participation is the lack of clear remuneration outside of the public medical service and lack of Medicare rebate. In Queensland,[19,20] as in the rest of Australia,[4,20] VAD workforce is an ongoing issue. There are also reports in Queensland of a strain on the public VAD system in terms of workload of providers[19] and local VAD nurse coordinators.[9] A wider workforce is needed to ensure the sustainability of the VAD service, and GPs are an untapped resource to assist with this. This would require adequate remuneration through an appropriate Medicare rebate for increased GP participation to be viable.[4,8]

Logistical barriers to participation identified here include the time required and demands of paperwork, which are known challenges in Australia resulting from the VAD process.[4–6] Changes in law and policy would be required to address these issues; however, designated time, or clear remuneration to allow for allotted paid time within usual general practice, may overcome these barriers to GP participation in VAD.

Future support to assist GPs and ongoing education on VAD might also affect future participation. Although GPs are well suited to VAD provision because of their generalist nature, there is an ongoing need for further education on VAD. This is seen in other jurisdictions in Australia and internationally after VAD is legalised.[17,18,21–25] This need for further education is not only for those who are willing and interested in being involved in the VAD process. Those who are not going to become authorised practitioners might still want education to enable them to support their patients through this process or after being assessed as ineligible, or enable them to discuss VAD as an option with patients when talking about end-of-life options. This highlights the need for more established education on VAD and how to discuss it with patients, when appropriate.

Limitations

Participants in this study were doctors with no in-principle objection to VAD and do not represent a full range of opinions on VAD, including those with objections. A further limitation is that this study was conducted in one state of Australia, and although some observations might be generalisable to other states, other observations might be more relevant to the distinctive VAD system design in Queensland. As this study took place after VAD been operating for 1 year, the service was still relatively new. Accordingly, our findings might not translate to more established services, as experiences and influences on participation may evolve over time. Further research would be useful to explore whether GP participation factors evolve as VAD becomes an established service.

Conclusion

GPs' involvement with VAD over the first year in Queensland was varied, from no involvement to participation in a large number of cases. This study highlights how GPs are well suited to VAD provision with their generalist approach to care; however, there are ongoing structural and logistical barriers to further GP participation. This includes the need for appropriate remuneration outside the public health service, such as a Medicare rebate, and the need for further education on VAD to support GP knowledge and participation.

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References

1. Voluntary Assisted Dying Review Board Victoria. Annual report July 2022 to June 2023. Victoria Safer Care, 2023. Available at www.safercare.vic.gov.au/sites/default/files/2023-08/VADRB%20Annual%20Report%202022-23.pdf [Accessed 20 March 2025].
2. Voluntary Assisted Dying Board Western Australia. Annual Report 2023–24. Government of Western Australia, Department of Health, 2024, p. 61. Available at www.health.wa.gov.au/~/media/Corp/Documents/Health-for/Voluntary-assisted-dying/VAD-Board-Annual-Report-2023-24.pdf [Accessed 20 March 2025].

3. Voluntary Assisted Dying Commission. Voluntary Assisted Dying Commission Annual Report 2023-24. Tasmanian Government Department of Health, 2024, p. 50. Available at www.health.tas.gov.au/sites/default/files/2024-09/voluntary_assisted_dying_annual_report_2023-24.pdf [Accessed 20 March 2025].
4. Lamba GT, LaBrooy C, Lewis S, et al. Voluntary assisted dying: Impacts on health professionals. Aust Health Rev 2024;48(6):720–28. doi: 10.1071/AH24142.
5. Rutherford J, Willmott L, White BP. What the doctor would prescribe: Physician experiences of providing voluntary assisted dying in Australia. Omega (Westport) 2023;87(4):1063–87. doi: 10.1177/00302228211033109.
6. Sellars M, White BP, Yates P, Willmott L. Medical practitioners' views and experiences of being involved in assisted dying in Victoria, Australia: A qualitative interview study among participating doctors. Soc Sci Med 2022;292:114568. doi: 10.1016/j.socscimed.2021.114568.
7. Willmott L, White BP, Sellars M, Yates PM. Participating doctors' perspectives on the regulation of voluntary assisted dying in Victoria: A qualitative study. Med J Aust 2021;215(3):125–29. doi: 10.5694/mja2.51123.
8. Haining CM, Willmott L, Towler S, White BP. Access to voluntary assisted dying in Australia requires fair remuneration for medical practitioners. Med J Aust 2023;218(1):8–10. doi: 10.5694/mja2.51787.
9. White BP, Ward A, Feeney R, Ley Greaves L, Willmott L. Models of care for voluntary assisted dying: A qualitative study of Queensland's approach in its first year of operation. Aust Health Rev 2024;48(6):693–99. doi: 10.1071/AH24199.
10. Braun V, Clarke V. Thematic analysis: A practical guide. SAGE Publications, 2021; p. 376.
11. Tran M, Grant M, Clayton J, Rhee J. Advance care decision making and planning. Aust J Gen Pract 2018;47(11):753–57. doi: 10.31128/AJGP-06-18-4613.
12. Mitchell GK. End-of-life care for patients with cancer. Aust Fam Physician 2014;43(8):514–19.
13. Mounsey L, Ferres M, Eastman P. Palliative care for the patient without cancer. Aust J Gen Pract 2018;47(11):765–69. doi: 10.31128/AJGP-07-18-4625.
14. Grant MP, McCarthy D, Kearney C, et al. General practice utilisation by Australian cancer patients in the last year of life. Fam Pract 2025;42(2):cmae062. doi: 10.1093/fampra/cmae062.
15. Mitchell GK, Senior HE, Johnson CE, et al. Systematic review of general practice end-of-life symptom control. BMJ Support Palliat Care 2018;8(4):411–20. doi: 10.1136/bmjspcare-2017-001374.
16. Ding J, Johnson CE, Saunders C, et al. Provision of end-of-life care in primary care: A survey of issues and outcomes in the Australian context. BMJ Open 2022;12(1):e053535. doi: 10.1136/bmjopen-2021-053535.
17. Ten Cate K, van Tol DG, van de Vathorst S. Considerations on requests for euthanasia or assisted suicide; a qualitative study with Dutch general practitioners. Fam Pract 2017;34(6):723–29. doi: 10.1093/fampra/cmx041.
18. Borgsteede SD, Deliens L, Graafland-Riedstra C, Francke AL, van der Wal G, Willems DL. Communication about euthanasia in general practice: Opinions and experiences of patients and their general practitioners. Patient Educ Couns 2007;66(2):156–61. doi: 10.1016/j.pec.2006.10.006.
19. Ley Greaves L, Willmott L, Feeney R, White BP. Changing perspectives on participation in assisted dying in Queensland, Australia: A one-year qualitative longitudinal study of doctors. Death Stud 2025:1–13. doi: 10.1080/07481187.2025.2510475. Epub ahead of print.
20. Ley Greaves L, Feeney R, Willmott L, White BP. Voluntary assisted dying in Queensland: Doctors' perceptions of its first year of operation. Aust Health Rev 2025;49(4). doi: 10.1071/AH25055.
21. Haining CM, Willmott L, White BP. Sustaining the workforce: A qualitative study exploring voluntary assisted dying supports and self-care. Intern Med J 2025;55(6):1001–12. doi: 10.1111/imj.70067.
22. Upshur R. Unresolved issues in Canada's law on physician-assisted dying. Lancet 2016;388(10044):545–47. doi: 10.1016/S0140-6736(16)31255-7.
23. Ganzini L, Nelson HD, Schmidt TA, Kraemer DF, Delorit MA, Lee MA. Physicians' experiences with the Oregon Death with Dignity Act. N Engl J Med 2000;342(8):557–63. doi: 10.1056/NEJM200002243420806.
24. Ley Greaves L, Willmott L, Feeney R, White BP. Preparing for voluntary assisted dying: A qualitative analysis of practitioners' perceptions of voluntary assisted dying before the law begins in Queensland, Australia. Death Stud 2025:1–15. doi: 10.1080/07481187.2025.2502985.
25. Li M, Watt S, Escaf M, et al. Medical assistance in dying – Implementing a hospital-based program in Canada. N Engl J Med 2017;376(21):2082–88. doi: 10.1056/NEJMms1700606.

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