

# Victoria's Voluntary Assisted Dying Act: navigating the section 8 gag clause

Section 8 is an unwarranted infringement on communication between health practitioners and their patients

In November 2017, the state of Victoria passed the *Voluntary Assisted Dying Act 2017* (Vic), legalising a model of voluntary physician-assisted death for adults at the end of life who meet a number of criteria, including rigorously assessed diagnostic and prognostic requirements. The Act came into effect on 19 June 2019. Its implementation raises a host of challenges.<sup>1</sup> Here we focus on one aspect of the new law that has been largely overlooked in ethico-legal debates thus far — the section 8 gag clause.

## Overview of section 8

Section 8 of the Act details a new legal prohibition specific to the practice of voluntary assisted dying. Section 8 states:

- (1) A registered health practitioner who provides health services or professional care services to a person must not, in the course of providing those services to the person—
  - (a) initiate discussion with that person that is in substance about voluntary assisted dying; or
  - (b) in substance, suggest voluntary assisted dying to that person.<sup>2</sup>

Significantly, this provision prevents all health practitioners registered with the Australian Health Practitioner Regulation Agency (AHPRA) from initiating a discussion of voluntary assisted dying with their patients, not only eligible providers of voluntary assisted dying. Breaching the requirements of section 8 will be considered “unprofessional conduct”, as regulated by the Health Practitioner Regulation National Law.<sup>2</sup> Breaches may result in AHPRA revoking a health practitioner’s licence.

The Victorian government proclaimed their model of voluntary assisted dying to be the safest and most conservative in the world.<sup>3</sup> In developing the 68 safeguards embedded in the Victorian regime, the Ministerial Advisory Panel on Voluntary Assisted Dying (the Panel) compared the then-proposed legislation with eight existing models of physician-assisted death implemented across Canada, Europe and the United States. Notably, Victoria is the only jurisdiction to prohibit health practitioners from initiating discussions about voluntary assisted dying.<sup>4</sup> Before the Act came into effect, health practitioners remained free to discuss voluntary assisted dying with patients, including its status as a soon-to-be lawful option.

The stated intent behind section 8 is not to discourage open discussion, but to ensure that patients are not coerced or unduly influenced into accessing voluntary assisted dying.<sup>4,5</sup> Although this aim is undeniably important, the Panel offered no evidence from other jurisdictions that such coercion has previously



occurred. Indeed, it cited research indicating that “fears that people from particular groups will be pushed into making such requests are ill-founded”.<sup>4</sup> Given the Act’s numerous other safeguards to ensure voluntariness, a mandate against health practitioners initiating discussion with patients is unnecessary.

By law, health practitioners are under no obligation to present patients with all available or possibly pertinent treatment options.<sup>4,6</sup> However, preventing practitioner-initiated discussion of a specific lawful option is an approach to patient communication that undermines some widely endorsed professional, ethical standards. It is also inconsistent with other aspects of elective (ie, non-clinically indicated) health care in Victoria. While voluntary assisted dying may not be relevant to the practice of most health practitioners, all health practitioners need to be aware of section 8, such that they do not inadvertently break the new law by mentioning voluntary assisted dying to patients within their care.

## Implications of the section 8 gag clause

Section 8 carries a number of implications for health practitioners and patients. First, it creates a tension between core professional, ethical and legal obligations contained in relevant codes of conduct for health practitioners. The Medical Board of Australia’s code of conduct for doctors emphasises providing treatment options based on the best available information (section 2.2.6) and honesty as a core guiding principle in working with patients (section 3.2).<sup>7</sup> Section 8 places health practitioners in a bind that compromises these stated professional expectations, and the principle of patient autonomy.<sup>8</sup> In order to make voluntary and informed end-of-life decisions, including the decision not to undertake voluntary assisted dying, patients should have all the relevant options presented to them by their health practitioner. This obligation arises in recognition of the superior medical knowledge health practitioners typically possess relative to their patients, and the social duty they have as trusted sources of health information.

Second, health practitioners may be receiving conflicting messages regarding whether and how section 8 will

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change current approaches to end-of-life discussions. On the one hand, the state has established voluntary assisted dying as a lawful end-of-life choice, while on the other hand, with section 8, the state has simultaneously legally prohibited health practitioners from initiating discussion of this option. Regardless of the intent behind it, section 8 poses an unprecedented infringement on the health practitioner–patient relationship and goes much further than is reasonably necessary to provide adequate safeguards against undue influence. It may end up preventing, rather than protecting, many patients from accessing this lawful health service. Section 8 could also be seen as sending the message that health practitioners cannot be trusted to determine the circumstances in which initiating a conversation about voluntary assisted dying might be appropriate.

Third, unknown to them, section 8 places a burden of prior knowledge of voluntary assisted dying on patients. It is unclear how legislators expect patients to glean enough knowledge to ask, in specific enough terms, about voluntary assisted dying, if they are unable to be informed by health practitioners. Certain groups may end up missing vital information that could impact their end-of-life choices, particularly those with lower levels of health literacy. Everyone should be able to trust their doctor to bridge education divides that are exacerbated by disadvantage.

It is unclear how these competing sets of ethical and legal duties are expected to interact, and what effect section 8 will have on trust in health practitioners. Additionally, section 8 may prove to be a source of moral distress for health practitioners, wherein external constraints — here, the legally prescribed gag clause — prevent health practitioners from acting in accordance with their genuine belief of what is the right thing to do (eg, openly and honestly providing patients with relevant information).<sup>9,10</sup>

Other jurisdictions may be influenced by section 8 of the Victorian Act and include an equivalent provision in their own voluntary assisted dying legislation. Of note, the Western Australian Ministerial Expert Panel on Voluntary Assisted Dying has recommended that WA legislation does not include such a provision. In alignment with our position, the WA Panel noted that “health practitioners have a professional obligation to ensure that their patients are fully informed about their choices at end of life, including voluntary assisted dying”.<sup>11</sup> To this end, it recommended that WA legislation allow health practitioners to initiate discussions about voluntary assisted dying with patients.

### Navigating the section 8 gag clause in clinical practice

For those providing care in a context in which voluntary assisted dying may be relevant, navigating treatment planning discussions in the shadow of section 8 will be particularly burdensome. A series of possible workarounds to section 8 have been proposed. The Victorian Department of Health and Human Services guidance for health practitioners states:

[Unless] a patient specifically asks about voluntary assisted dying, the conversations that

health practitioners currently have with patients about end-of-life care should not change after the Voluntary Assisted Dying Act commences.

Broad questions such as ‘What are my options at the end of my life?’ do not constitute requests for information about voluntary assisted dying. Requests for information must be specific and explicit.<sup>5</sup> [emphasis added]

Following this guidance, if a health practitioner is unsure whether or not their patient is asking about voluntary assisted dying, they are instructed to ask open-ended questions in order to clarify what the patient is considering.

Conservative approaches to end-of-life conversations adhere to, rather than overcome, the constraint imposed by section 8. Asking open-ended questions may provide insufficient guidance for patients who do not know enough to even ask about voluntary assisted dying as a possible option; know about voluntary assisted dying but do not feel comfortable raising it with their health practitioner; expect their health practitioner to raise options they judge to be relevant; and are seeking general information about end-of-life planning and care and want to be presented with a range of possible options (from which, under section 8, voluntary assisted dying will be intentionally excluded). Health practitioners should be able to exercise their clinical judgement as to whether a conservative or a more open approach is suitable for a particular patient at a particular time.

In lieu of initiating a discussion verbally, health practitioners can direct patients to the Department of Health and Human Services end-of-life care webpage,<sup>12</sup> which provides information about advance care planning, palliative care and voluntary assisted dying. Still, the onus is on the patient to find information on voluntary assisted dying, which they can then explicitly ask their health practitioner about. In this roundabout way, health practitioners are able to direct patients to a source of information about voluntary assisted dying, without violating section 8. Another workaround might be for health services to appoint a non-AHPRA-registered voluntary assisted dying “navigator”, such as a clinical ethicist or patient advocate, who would not be bound by section 8. While feasible, these possible workarounds do nothing to address the underlying problems created by section 8.

While Victoria celebrates introducing voluntary assisted dying as a new end-of-life choice, section 8 presents a significant barrier for the health practitioners tasked with facilitating it. Ultimately, successful implementation of the voluntary assisted dying legislation will be influenced by how health practitioners understand their obligations to their patients.

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