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## **Constitution of ‘The Already Dying’: The Emergence of Voluntary Assisted Dying in Victoria**

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**Abstract** In June 2019 Victoria became the first state in Australia to permit ‘voluntary assisted dying’ (VAD), with its governance detailed in the *Voluntary Assisted Dying Act 2017* (Vic) (‘VAD Act’). While taking lead from the regulation of medically-assisted death practices in other parts of the world, Victoria’s legislation nevertheless remains distinct. The law in Victoria only makes VAD available to persons determined to be *already dying*: it is expressly limited to those medically prognosed to die “within weeks or months”. In this article, we discuss the emergence of the Victorian legislation across key formative documents. We show how, in devising VAD exclusively for those “already at the end of their lives”, the Victorian state mobilises the medico-legal category of *the already dying*. We argue that this category functions to negotiate a path between what are seen as the unacceptable alternatives of violent suicide on the one hand, and an unlimited right to die on the other. Further, we argue that the category of the already dying operates to make medical practitioners the gatekeepers of end of life choices, and effectively limits the realisation of autonomy at the end of life.

**Keywords** Voluntary Assisted Dying; Physician-Assisted Suicide; Active Voluntary Euthanasia; Assisted Death; Dying; Health Law; Autonomy

# Constitution of ‘The Already Dying’: The Emergence of Voluntary Assisted Dying in Victoria

Assisted dying should provide an option that can limit suffering at the very end of life, not a way to end life for those who are otherwise not dying.

(Parliament of Victoria Legislative Council  
Standing Committee on Legal and Social Issues 2016, 224)

## Introduction

On 19 June 2019, Victoria became the first state in Australia to permit ‘voluntary assisted dying’ (herein ‘VAD’), with its governance detailed in the *Voluntary Assisted Dying Act 2017* (Vic) (hereafter ‘VAD Act’). Broadly, VAD refers to “assistance to die provided in a medical context” (Parliament of Victoria Legislative Council Standing Committee on Legal and Social Issues (hereafter ‘VLC LSIC’) 2016, 14), and encompasses life-ending practices that are often distinguished as physician-assisted suicide and active voluntary euthanasia (see White and Willmott 2012). While taking lead from the regulation of medically-assisted death practices akin to VAD in other parts of the world, Victoria’s legislation nevertheless remains distinct. While retaining the requirement for decision-making capacity of many ‘end of life’ laws (Hempton and Bhatia 2020), the VAD Act in Victoria also requires that VAD only be made available to persons determined to be *already dying*: it is expressly limited to those medically prognosed to die “within weeks or months” (s 9.1.d.iii)—those “*already* at the end of their lives” (State of Victoria Department of Health and Human Services 2017a, 44, our emphasis). We examine how, in devising VAD exclusively for the already dying, the state constructs and mobilises the medico-legal category of *the already dying*.

In this paper, we analyse the construction of the category of the already dying in relation to VAD, and the principles that underpin it, to outline the function and implications of this category. We argue that it works to negotiate a path that is morally and politically palatable for the Victorian government between violent suicide on the one hand, and the notion of a ‘right to die’ on the other. Further, we highlight the way that the category of the already dying positions medical practitioners involved in VAD as gatekeepers—access to medically-assisted death is not a right in Victoria, but is thoroughly delimited and managed by medical practitioners and the state. The upshot of this is that the VAD Act is limited in terms of expanding end of life ‘choice’ and autonomy. Thus, while a welcome first step, the VAD Act may be a double-edged sword for many in favour of expanding end of life options, insofar as it comes to set the tone for further legislation in Australia.

To spell out how the category of the already dying is mobilised in the governance of VAD in Victoria, in Section One of this paper we outline the process by which the VAD Act

was developed and came into effect. In Section Two, we take a brief look at how the VAD Act aligns with other legislation in the state to show how a legal space for the legitimate intentional killing of a patient has been made. In Section Three, we examine the eligibility criteria that govern access to VAD to highlight how these delimit the medico-legal category of the already dying, particularly through the tripartite scheme of temporal, cognitive, and physical requirements. From this, in Section Four, we consider further implications of the constitution of the category of *the already dying*, especially in relation to the role of medical practitioners and autonomy at the end of life.

On a terminological note, the term ‘voluntary assisted dying’ is utilised in Victoria, and increasingly in other jurisdictions in Australia, and throughout the paper we accordingly adopt this terminology (abbreviated to VAD). However, in early stages of the law reform process within Victoria, the term ‘assisted dying’ was used to advance what later became ‘voluntary assisted dying’; occasionally, then, we use the term ‘assisted dying’ when required to accurately reflect the emergence of VAD.

## **I. The Emergence of ‘Voluntary Assisted Dying’**

The law reform process by which the VAD Act came into being took place through the years 2015-2017. It began with a state Parliamentary Inquiry into End of Life Choices (hereafter the ‘Inquiry’), established in May 2015, conducted by an inter-party Legal and Social Issues Committee (Legislation and References) (hereafter the ‘Committee’). The Committee was tasked with inquiring into and reporting on “the need for laws in Victoria to allow citizens to make informed decisions regarding their own end of life choices” (VLC LSIC 2016, xiii). Within a broad remit, the Inquiry was established to review and assess end of life regulations, including existing frameworks, legislation, and practices, in addition to proposed and enacted legislation from across Australian and international jurisdictions. Specifically, the Committee was established to “assess the practices currently being utilised within the medical community to assist a person to exercise their preferences for the way they want to manage their end of life” (VLC LSIC 2016, xiii), and sought “community views on the need for laws to allow people broader scope in their end of life choices” (VLC LSIC 2015).

The Committee received over a thousand<sup>i</sup> written submissions to the Inquiry from members of the public, including individuals and organisations. Despite the Inquiry’s broad purview, the “overwhelming majority” (VLC LSIC 2016, 4) of individual public submissions addressed the issue of ‘assisted dying’, including a number that “disclosed involvement in another’s suicide or in assisted dying” (VLC LSIC 2016, 4), despite the illegality of such actions. Subsequently, the Committee conducted 17 days of formal hearings across the state of Victoria, receiving witness testimony from representatives of government agencies and departments, non-government organisations and institutions, and also from individuals in a personal capacity (VLC LSIC 2016, 3-6). During March and April 2016, five members of the Committee visited five international jurisdictions in

four countries (Montreal and Ottawa in Canada, the Netherlands, Oregon in the USA, and Switzerland), in which some form of medically-assisted death is permitted. The purpose of these visits was to explore the development and operation of different frameworks for regulating medically-assisted death, including eligibility criteria, safeguards, and reporting mechanisms (VLC LSIC 2016, 7).

As a result of the Inquiry, assisted dying legislation was ultimately recommended, specifically as a solution to the perceived problems of suicide and suffering at the end of life. The Committee reported that “too many Victorians who experience an irreversible deterioration in their physical health, many of whom are elderly and frail, take drastic and brutal measures to end their lives” (2016, 169). One of the Committee’s key findings was that “[p]rohibition of assisted dying is causing some people great pain and suffering. It is also leading some to end their lives prematurely and in distressing ways” (2016, 15); in other words, the prohibition of VAD was leading to prolonged suffering and suicide. In light of this, the Committee concluded that “the current legal framework is not serving Victorians well” (2016, 206), ultimately recommending that “the Victorian Government introduce a legal framework providing for assisted dying” (2016, 213).

In response to the Committee’s recommendation, the state government convened a Ministerial Advisory Panel on Voluntary Assisted Dying (hereafter the ‘Panel’). Broadly, the Panel was tasked with refining the ‘assisted dying framework’ proposed by the Committee (2016), including examining legal and policy issues related to the operationalisation of VAD. Initially the Panel released a ‘Voluntary Assisted Dying Bill discussion paper’ for expert consultation (State of Victoria Department of Health and Human Services 2017b), and reported on this process in an interim report (State of Victoria Department of Health and Human Services 2017c). In its subsequent final report, the Panel outlined a series of recommendations regarding the operationalisation of VAD, detailing the eligibility criteria, request and assessment process, oversight mechanisms, and implementation considerations (State of Victoria Department of Health and Human Services 2017a), most of which was maintained in the eventual legislation.

Notably, the Panel referenced the *Charter of Human Rights and Responsibilities Act 2016* (Vic) (hereafter the ‘Charter’), and “considered how the relevant human rights identified in the Charter can be promoted” (State of Victoria Department of Health and Human Services 2017a, 43) via VAD.<sup>ii</sup> While a detailed account of the Panel’s deliberations regarding the interaction between various human rights and VAD is beyond the scope of this paper, it is important to note the Panel concluded that its recommended model of VAD was compatible with the existing rights identified in the Charter, and that VAD need not be established as a ‘right’ as such. In determining its recommendations, the Panel “sought to strike a balance between: a person’s desire to make autonomous decisions about the timing and manner of their death; and a framework that provides the appropriate safeguards for Victorians who may be at risk of abuse” (State of Victoria Department of

Health and Human Services 2017a, 211). Further, the Panel contended that “[t]o create a safe and compassionate [VAD] legislative framework, it is necessary to limit some human rights to ensure people are protected from abuse” (State of Victoria Department of Health and Human Services 2017a, 210). In summary, the right to autonomy, especially *vis a vis* dying, had to be limited to protect the vulnerable from potential abuse. We return to this point further below.

The *Voluntary Assisted Dying Bill 2017* (Vic) was introduced to parliament on 21 September 2017 by then state Minister for Health Jill Hennessy (Vic Parliamentary Debates Legislative Assembly). The Bill passed the Victorian Legislative Assembly (the Lower House), without amendment, though a number of amendments were passed in the Victorian Legislative Council (the Upper House), and later ratified in the Lower House. Ultimately, the *Voluntary Assisted Dying Act 2017* (Vic) was passed on 29 November 2017 and came into effect on 19 June 2019.

## II. Distinguishing Voluntary Assisted Dying

The VAD Act marked a definitive departure from numerous failed attempts to introduce medically-assisted death in Australian jurisdictions (see Willmott et al. 2016). It is already informing and shaping legal reform around end of life decision-making in other Australian states and can be anticipated to do so for some time.<sup>iii</sup> Given the historical significance and likely influence of the Victorian model, it is worth examining the underpinning claims of this legislation in some detail. In particular, in this section, we consider how the VAD legislation juxtaposes with other relevant legislation governing life-ending practices.

One key feature of the VAD Act is that it allows legal space for the *intentional* termination of the life of a patient (i.e. killing), and is thus distinguishable from alternative ‘death-hastening’ medical practices, in which death may be reasonably foreseeable but not *intended* (Sumner 2011, 73). These include withholding or withdrawing ‘life-sustaining’ treatment, the refusal of nutrition and hydration (including ‘voluntary stopping eating and drinking’, and ‘voluntary palliated starvation’) (see White, Willmott, and Savulescu 2014), and ‘continuous terminal sedation’ (see Quill, Lo, and Brock 2008). In contrast to these practices (exploited under the doctrine of double effect), the objective of VAD is unequivocal: the purpose of VAD is the intentional termination of human life. The Act defines VAD as “the administration of a voluntary assisted dying substance and includes steps reasonably related to such administration” (s 3), where a ‘voluntary assisted dying substance’ is considered to be “a poison or controlled substance or a drug of dependence specified in a voluntary assisted dying permit for *the purpose of causing a person’s death*” (s 3, our emphasis). As this makes clear, death is not merely a side-effect arising from an action with some other primary intent—death is the foreseeable and *intended* outcome of VAD.

This means that the introduction of VAD requires a fundamental shift in the regulation of the intentional ending of a life and associated practices. Practices similar to VAD, in intending to bring about death of another, are currently unlawful in all Australian jurisdictions (VLC LSIC 2016, 12). As regulated by the *Crimes Act 1958* (Vic) in Victoria, acts involved in aiding or abetting the commission of suicide (s 6B.2.b) or other forms of homicide are considered ‘offences against the person’. In the *Crimes Act 1958* in place in Victoria, it is lawful for one to attempt to commit or to commit suicide (s 6A). At the same time, it is unlawful to provide assistance for someone to commit suicide (s 6B.2). It is also lawful for ‘every person’ to justifiably *prevent* both the commission of suicide or any act that would amount to suicide (s 463.b). Further, in the context of apparent or medically-assessed ‘mental illness’, the *Mental Health Act 2014* (Vic) provides for the prevention of ‘serious harm to the person’ in a variety of ways, noted as justification for non-voluntary or involuntary apprehension and assessment, and confinement and treatment in certain circumstances. Means for preventing suicide may include psychiatric assessment and urgent treatment, seclusion, bodily restraint (s 113.a), sedation and apprehension by the police.

Interestingly, some aspects of VAD practices could be seen as falling within this remit, in particular providing assistance to another person to enable them to self-kill, in addition to acting to intentionally kill another at their request. However, with the VAD Act, the Victorian government appears to have implemented legislation that carves out a space for both lawful aiding and abetting of suicide and lawful homicide in certain circumstances. To be clear though, the introduction of VAD made no change to the criminal regulation of these acts; rather, VAD is established as a distinct practice, and is not considered with reference to the criminal framework governing assisting suicide.

The key question, then, is in what circumstances is the intentional causing of death considered lawful? The answer to this question is delineated in the eligibility criteria that govern who can access to VAD. The eligibility criteria set out in the VAD Act delineate those who qualify for assistance to die by means of VAD, and concomitantly excludes those judged to not meet those criteria. As we articulate in the following section, the category of the already dying is central to this delineation: the insistence on and mobilisation of this category allows the state to make a legal space for assisting the intentional termination of the life of another.

### **3. Eligibility for Voluntary Assisted Dying: Constitution of ‘The Already Dying’**

The medico-legal category of *the already dying* is delineated through the eligibility criteria that constrain the scope of access to VAD. As we show below, the category of *the already dying* is marked by three particular characteristics, that is, (i) the temporal (ii) the cognitive and (iii) the physical elements, set out in the eligibility criteria for VAD. Importantly, none of these criteria are sufficient in themselves to permit access to VAD;

rather, all the criteria are necessary, and as such operate in deep connection to each other. In the following discussion, we outline each of these characteristics before moving on to consider some of the implications of the category of the already dying further. While we focus on the eligibility criteria as enacted in the VAD Act now in effect, some notable shifts emerged throughout the law reform process in regard to these criteria. Where relevant, then, we trace changes between the reports issued by the Committee and the Panel, and as proposed in the initial *Voluntary Assisted Dying Bill 2017* (Vic), as compared to the final Act.

### 3.1 Temporal Elements

It is in the temporality of death that the category of the dying receives its most explicit formulation and mobilisation. This is because in the state's composition of VAD, one must be '*already dying*' to justify the assisted termination of life. As explained by the state's Department of Health and Human Services, "[o]nly those who are *already dying* from an incurable, advanced and progressive disease, illness or medical condition will be able to access voluntary assisted dying" (n.d., our emphasis). As elaborated in the Act, access to VAD is limited to those expected to die "within weeks or months" (s 9.1.d.iii), though different time caveats apply depending on the diagnosis. In the case of "a disease, illness or medical condition that is neurodegenerative, that disease, illness or medical condition must be expected to cause death within weeks or months, *not exceeding 12 months*" (s 9.4, our emphasis), whereas for all other diagnoses, the 'disease, illness or medical condition' must be "expected to cause death within weeks or months, *not exceeding 6 months*" (s 9.1.d.iii, our emphasis).

These timeframes for being 'already dying', divided by the kind of disease, illness, or medical condition, are the result of a number of changes introduced throughout the process of legislative development. Following the Inquiry, the Committee initially adopted a less specific approach in terms of prognosis, recommending VAD be accessible by those "at the end of life (final weeks or months of life)" (2016, 223). While the Committee emphasised that VAD is "*not* a way to end life for those who are *otherwise not dying*" (2016, 224, our emphasis), the 'final weeks or months of life' was deliberately left undefined and ambiguous. In respect to determining whether or not a person is 'already dying' (or 'otherwise not [already] dying'), the Committee recommended that "empowering doctors to make this assessment is preferable to allocating an arbitrary time limit" (2016, 224). In the view of the Committee, "[d]octors are best placed to assess whether a patient is at the end of life ... according to the nature of their condition and its likely trajectory" (2016, 224). Despite declining to define an 'arbitrary time limit', the Committee anticipated the proposed model of VAD "would in practice apply to those with weeks or months to live, not years" (2016, 224).

Later, in reviewing the Committee’s recommendation, the Ministerial Advisory Panel shifted toward a definite cut-off. The Panel determined “the words ‘end of life (final weeks or months of life)’ require further clarification” (2017a, 71), concluding “this ambiguity is likely to lead to confusion among the community and medical practitioners who will need guidance as to the parameters around who may access voluntary assisted dying” (2017a, 71). After considering a range of timeframes, including the ‘foreseeable future’, 6 months, 12 months, 18 months, and 24 months (see State of Victoria Department of Health and Human Services 2017a, 71-74), the Panel recommended the timeframe be specified as “within weeks or months, but not longer than 12 months” (2017a, 71). The Panel ultimately determined that a 12-month timeframe fit best with existing approaches to end of life policy in the state, and accords with the so called ‘surprise question’ already utilised by some health practitioners in respect to care planning—that is, “Would I be surprised if my patient died in the next 12 months?” (State of Victoria Department of Health and Human Services 2017a, 73). The 12-month timeframe as recommended by the Panel appears in the initial *Voluntary Assisted Dying Bill 2017* as introduced and passed by the Lower House, though an amendment to change the timeframe was subsequently introduced and passed in the Upper House, and later ratified in the Lower House.

This raises the question of how it can be determined that a person is *already dying*, given the designated timeframes. Despite reporting the ‘surprise question’ as relevant to the recommended ‘number of months’ approach to eligibility, and referring to empirical research examining the utility of the ‘surprise question’ in care planning, the Panel cautioned that it “would not be appropriate for assessing the Panel’s recommended eligibility criteria” (2017a, 71). However, while discrediting the surprise question approach, the Panel does not offer an alternative method for reliably assessing this criterion.

The timeframes eventually specified in the Act are momentous in terms of the potential inclusion and exclusion of particular persons. All things being equal, those who are ‘already dying’ are permitted access to VAD, while those ‘otherwise not already dying’ are prohibited from accessing VAD. One assumption underlying this is that persons are in fact able to be categorised as either ‘already dying’ or ‘otherwise not dying’ (the not-already dying) definitively and accurately. Beyond the clinical challenge of accurately categorising people as either already dying or not, the criterion that a person be already dying raises fundamental questions—in the context of state-regulated VAD, why is being already dying significant? Perplexingly, there is no underlying Principle in the Act that explicitly justifies limiting access to VAD to those ‘already dying’, and little of the surrounding debate addressed the moral aspects of the requirement to be ‘already dying’ to be eligible for VAD.



### 3.2. Cognitive Elements

The temporal dimension of the already dying connects to two other elements, both of which place further limits on the category of the already dying. A central component of Victoria's VAD regime is the individual's capacity to make voluntary decisions about assisted dying. The Act does not include provisions for either 'involuntary' or 'non-voluntary' assisted dying, and the centrality of voluntariness is indicated in the very naming of the Act. Indeed, the Panel modified the Committee's original term of 'assisted dying' to 'voluntary assisted dying', as adopted in the Act, in order to emphasise voluntariness. In 'a note on language' the Panel acknowledges how terminology employed to describe the process of VAD "suggests some form of value judgement about the process, but also frames who is perceived to be in control of the process and what is perceived to be occurring" (2017a, 7). The Panel considered and discounted a number of other possible terms, including 'euthanasia', 'dying with dignity', 'assisted suicide', and 'assisted dying' (see State of Victoria Department of Health and Human Services 2017a, 7-8), though the Panel did not consider the term 'medical assistance in dying' recently adopted in Canada. Notably, 'physician-assisted suicide' was dismissed because of the stigma associated with the term suicide. Instead, the Panel preferred 'voluntary assisted dying' because it "puts the focus on the term 'voluntary' as an emphatic statement that this is a decision initiated by a person who is suffering and who takes responsibility for the decision" (2017a, 8). Thus, the explicit 'voluntariness' added to the original term accentuates an individual's personal responsibility for the decision to die.

Many of the proclaimed '68 safeguards' (see State of Victoria Department of Health and Human Services 2017a, 216-220) featured in the VAD Act effect the 'voluntary' aspect of VAD. As claimed by the Panel, "the additional *safeguards* it has recommended will ensure decisions in relation to VAD are *voluntary*" (2017a, 89, our emphasis). Foremost, the notion of voluntariness is operationalised in terms of eligibility for VAD as part of 'decision-making capacity'. As specified in the Act, a "person must have decision-making capacity in relation to voluntary assisted dying" (s 9.1.c). Decision-making capacity is defined in the Act per the general decision-relative definition adopted from the *Medical Treatment Planning and Decisions Act 2016* (Vic), which encompasses aspects of understanding, retention, and weighting of information, and communication of a decision (s 4.1.a-4.1d). By this definition, 'voluntariness' necessitates a decision—a 'choice'. In this sense, the notion of 'voluntary' in VAD functions at the level of informed decision-making and express consent—it does not enable broader conceptions of liberty or a 'right' to VAD.

The necessary decision-making capacity defined in the eligibility criteria are further elaborated in the Act through logistical processes for access to VAD. As operationalised, the notion of 'voluntariness' serves primarily as a constraint on action—a 'safeguard' to ensure the termination of life is satisfactorily requested. Most of the Act is devoted to delineating protocols to ensure the request for VAD is both "properly informed" (VLC

LSIC 2016, 226-227) and “properly considered” (VLC LSIC 2016, 227-228). The Act and associated regulations prescribe the ways in which information about VAD must be requested, followed by a series of formal assessment procedures conducted by a minimum of two specifically trained medical practitioners (with possible referral to other specialists), and ultimately signed off by the state with issuance of a ‘voluntary assisted dying permit’. Importantly, in assessing decision-making capacity in relation to VAD, Carmelle Peisah, Linda Sheahan, and Ben White (2019) note, “the decision [to request VAD] does not need to be objectively reasonable; the person only has to show evidence of reasoning” (2019, 7). Even so, evidence of such reasoning in the choice to die by VAD is applicable only to those who are *already dying*. People determined to be not-already dying are not permitted to access VAD, regardless of their decision-making capacity.

Importantly, it is essential that the person requesting access to VAD not only have capacity at the point of request but *throughout* the VAD process. The Panel determined “that requiring a person to have decision-making capacity *throughout* the VAD process represents an important safeguard to protect against abuse” (2017a, 58, our emphasis). Consequently, the Act explicitly prohibits an advance request for VAD via an advance care directive (s 140.a), and also prohibits a substitute-decision by a medical treatment decision-maker in relation to VAD (s 140.b), implemented via an amendment of the *Medical Treatment Planning and Decisions Act 2016* (inserting s 8A). One problematic implication of this may be that it forces people to die earlier than they otherwise might, in fear that their permission to access VAD may be rescinded after losing capacity—a point that may be particularly poignant for those seeking to use VAD for neurodegenerative conditions.

The explicit exclusion of VAD from advance care directives is in contrast to the state’s broader position on advance requests for medical treatment (see Hempton and Bhatia 2020). The primary stated purpose of the new *Medical Treatment Planning and Decisions Act 2016* is “to provide for a person to execute in advance a directive that gives binding instructions or expresses the person’s preferences and values in relation to the person’s future medical treatment” (s 1.a). To this end, the new legislation provides for two kinds of advance care directives; an instructional directive (a stated treatment decision), and a values directive (a statement of general preferences and values). Most notably, an instructional directive “takes effect as if the person who gave it has consented to, or refused the commencement or continuation of, medical treatment, as the case may be” (s 6.1). In effect, an instructional directive is a statement of consent, issued in advance at a time in which the person had decision-making capacity in relation to the specific decision, to be enacted at a later time when the person no longer has decision-making capacity in relation to the specific decision. Without recourse to either a consent-in-advance or proxy provision, those evaluated to not have decision-making capacity at any moment through the request and approval process are not eligible to access VAD.

That said, the Act is somewhat inconsistent regarding the duration or continuation of decision-making capacity in relation to VAD. In particular, the exclusion of advance care directives for VAD may be inconsistent with the potential trajectory of those approved for self-administration of VAD. The assessment of eligibility, issuance of a permit, and provision of the ‘voluntary assisted dying substance’ may be, per the temporal eligibility criteria, up to 6-12 months (or potentially longer depending on prognostic accuracy), in advance of a person self-administering the VAD substance. Yet, while there is a requirement that an additional assessment of decision-making capacity will occur at the time of an ‘administration request’ for practitioner administration (s 64), there is no legislated requirement for a decision-making capacity assessment at *the time* of self-administration. In the case of self-administration, anticipated to be the main way in which VAD is utilised in Victoria, there actually is no ‘safeguard’ to ensure decision-making capacity is maintained throughout the VAD process. In effect, there seems little difference between approval for self-administration months in advance as prescribed by the Act, with the potential for loss of decision-making capacity at the time of self-administration, and the prohibited request for VAD via an advance care directive: both requests could be made some time in advance when the person has decision-making capacity in relation to VAD, and enacted at a later time when the person may not or will not have the same decision-making capacity.

In sum, the operationalisation of cognitive elements required to access VAD appear more demanding than general standards for autonomous, medical treatment decision-making adopted by the state of Victoria in other contexts, including at the end of life. The evident effect of the cognitive criteria for access to VAD is the global exclusion of certain kinds of persons from enacting VAD. Of those who may otherwise meet the temporal and physical requirements (discussed below), those failing to meet the cognitive criteria will include adults anticipating the loss of decision-making capacity and wishing to make a request for VAD in advance, in addition to all children and adolescents. Further, those approved for VAD who require practitioner administration may also be later deemed ineligible if they do not have decision-making capacity at the time of requesting administration, *even if* they had that capacity at the point of being assessed as eligible for VAD. In short, the choice to die via VAD is approached differently than the choice to foreseeably die via other accepted medical modes, including withholding or withdrawing life-sustaining treatment.

### **3.3. Physical Elements**

The Act also conjoins the temporal aspect to a physical aspect by requiring that a person considered to be ‘already dying’ must be suffering from a disease, illness or condition that will cause death. There are two points to be made here. First, the relevant diagnosis must be expected to *cause* death within the applicable time period specified for the diagnosis (either neurodegenerative or not). As delineated in the Act, “the person must be

diagnosed with a disease, illness or medical condition that—(i) is incurable; and (ii) is advanced, progressive and *will cause death*” (s 9.d, our emphasis). In this manner, both the ‘incurability’ and ‘advanced, progressive, and will cause death’ elements of the criteria serve to cover what in other jurisdictions may be considered ‘terminal’, or a grievous and irremediable medical condition, with a reasonably foreseeable natural death. The term ‘terminal’ was considered by the Panel as too non-specific, as it may be considered by some to encompass diseases, illnesses, or medical conditions that are not *curable*, though may unfold over a longer period of time, such as dementia. The Panel concluded “the words ‘will cause death’ are more precise and will be better understood by health practitioners in Victoria” (2017a, 70). As a clinical task then, assessment of eligibility for VAD requires medical practitioners to determine a causal connection between ‘the disease, illness, or medical condition’ and an ‘inevitable, imminent death’.

In essence, the rationale for VAD is defined in terms of the lethality of a specific disease, illness, or medical condition, and the incapacity of current medical knowledge to alleviate that condition. Here, lethality is understood in terms of both ‘incurability’, and the causal relation of the disease to death, that is, that it will indeed *cause* death (in the timeframe as discussed above). The Department of Health and Human Services writes that, “[v]oluntary assisted dying is only for those who face an inevitable, imminent death as a result of an *incurable* disease, illness or medical condition” (n.d., our emphasis). The term incurable was consistently adopted throughout the law reform process by the Committee and the Panel, with the Panel noting the term “is well understood by medical practitioners to mean a medical condition that cannot be cured” (2017a, 67). In essence then, those ‘already dying’ may be distinguished from those ‘not otherwise already dying’ by medicine’s capacity to *cure* a specific disease, illness, or medical condition. In respect to VAD, being categorised as the living (i.e. the not already dying) or the already dying is a matter of medical capacity and expertise.

Second, the disease, illness, or medical condition must also cause ‘suffering’. As specified in the Act, “the person must be diagnosed with a disease, illness or medical condition that— ... (iv) is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable” (s 9.d). Subjective suffering is fused with diagnostic elements of the criteria in terms of the *cause* of suffering. The Panel “noted that for a person to become eligible for access to VAD, their *suffering should be causally linked* to their disease, illness or medical condition” (2017a, 77, our emphasis). This means that suffering that is not caused by the relevant disease, illness, or medical condition will not be grounds for accessing VAD; as the Committee asserted, “[s]uffering as a result of mental illness only does not satisfy the eligibility criteria” (2016, 223)—“[voluntary] assisted dying should provide an option that can limit suffering at the very end of life, not a way to end life for those who are otherwise not dying” (2016, 224). As extensive debates on end of life choice have made clear, the reasons why a person may wish to die are complex and issues regarding different kinds of subjective ‘suffering’ as a justification

(or not) for practices akin to VAD has received much theoretical and empirical discussion and we do not seek to intervene in these debates here.

The formulation of suffering adopted in the Act resulted from a number of changes introduced throughout the process of legislative development. The Committee initially proposed additional qualifications to the suffering component, recommending VAD be accessible by those “suffering from a serious and incurable condition which is causing enduring and unbearable suffering that cannot be relieved in a manner the patient deems tolerable” (2016, 223). In regard to considering the criteria and ‘safeguards’, the Committee writes, “in the shift towards patient-centred medicine the Committee believes it is not for others to decide what is and is not tolerable for a patient” (2016, 218). This connects to one of the ‘Core Values’ identified by the Committee, that is, that “[p]ain and suffering should be alleviated for those who are unwell” (2016, 16). In reviewing the Committee’s recommendation, the Ministerial Advisory Panel supported the relevant Core Value identified by the Committee and determined that “voluntary assisted dying legislation should provide an option for a small number of people whose pain and suffering cannot be relieved in a manner they deem tolerable to control the timing and manner of their death” (2017a, 75). While this intention does not specifically refer only to those ‘already dying’ in terms of ‘pain and suffering’, the Panel concluded: “the Victorian legislation should require that a person be approaching their death (the North American model) and be suffering (the European model). These dual requirements represent strong safeguards” (2017a, 76). In sum, suffering affords access to VAD, but only for those who are *already dying*—only those determined to be ‘already dying’ in a temporal sense, are afforded the avoidance of suffering via VAD.

Our point here is to draw attention to the causal connection between a disease, illness, or medical condition and subjective suffering required in the eligibility criteria, themselves further linked to the temporal condition that a person be ‘already dying’. How this causal connection will be distinguished in clinical practice is unclear. Even so, the causal conjunction of the ‘already dying’ condition with the suffering condition in the operationalisation of VAD in Victoria may avoid some of the difficulties identified in other jurisdictions that institute life expectancy requirements. For example, in considering what Australia might learn from the Canadian experience of implementing ‘medical assistance in dying’, legal scholar Jocelyn Downie notes the challenge of the ‘reasonably foreseeable’ death eligibility criterion, specifically that persons may intentionally create the circumstance for their death to be reasonably foreseeable, for example, “starving themselves to get close enough to death to qualify” (Downie 2017, 145). That the temporality of death must also be conjoined to a diagnosis and a determination of incurability, which is itself the reason for suffering, means that such scenarios may not emerge in Victoria. Thus, for all the emphasis on voluntariness, the spectre of a person voluntarily bringing about their own death is again held off.

#### IV. Implications of ‘The Already Dying’

Having set out and discussed the key criteria established for access for VAD above, in this section, we briefly consider some of the implications of this model. As we have illustrated, the state’s approach to VAD in Victoria mobilises the medico-legal category of *the already dying* as a crucial means of distinguishing between those eligible for access to VAD and those ineligible. As is evident from the foregoing, the eligibility criteria intersect and reinforce each other, such that none are necessary *and* sufficient—*all* are necessary, *none* are sufficient. Through them, the category of ‘the already dying’ is construed as a biological condition that is both diagnosable and prognosable by medical practitioners. We point to three notable implications of the category of the already dying and the intersections of these criteria with and within it.

First, the category of the already dying helps to negotiate a morally and politically acceptable path between the spectre of suicide on the one hand, and an unlimited right to die on the other. In constituting the category of the already dying, the state draws a distinction between approaches to suicide and to VAD, where the former is construed as a bad death and VAD as a good death. Note that we do not claim that suicide *is* a bad death while VAD *is* a good death; our point is only that this is how these different ways of dying are cast in the debates around VAD in Victoria. As we saw earlier, the regulation of self-killing entails that while suicide is legal, it is simultaneously legal to *prevent* suicide, and also *illegal* to assist suicide. This preventive approach is premised on the view that death by suicide is a form of self-harm. More specifically, VAD was cast as a remedy to cases of violent suicide linked to the prohibition of medical assistance to die. In effect, such deaths were to be avoided, while medically-assisted ‘suicide’ was cast as beneficent. Thus, VAD is premised on the notion that ‘suicide’ and ‘voluntary assisted dying’ can be categorically distinguished and treated accordingly—death by suicide ought to be prevented, while death with medical assistance may be permitted under delimited circumstances.

However, VAD was not only seen as a pragmatic solution to the practical problem of suicide; it is also cast as morally consistent with social values in contemporary Victoria. The VAD Act specifies ten ‘Principles’ that all those “exercising a power or performing a function or duty under this Act must have regard to” (s 5.1). The Principles are broadly adopted from a series of twelve ‘Core Values for End of Life Care’, which were created by the Committee that conducted the initial Inquiry (VLC LSIC 2016, 16). Based on its international research, the Committee determined “an assisted dying framework must incorporate the culture and values of the people it serves” (2016, 21). With this intent, the Committee considered “the legal and medical values and culture that are essential to all Victorians” (VLC LSIC 2016, 16), in order to “take the best of current practice, and implement it in a way that is suited to Victoria” (VLC LSIC 2016, 16). These initial Core Values were later then refined by the Panel into a series of nine ‘Guiding Principles’ (State of Victoria Department of Health and Human Services 2017a, 11). It is in light of

these Principles the state determines, foremost, that the practice of VAD is lawfully permissible in some circumstances, and further, that VAD is permissible only in the specific circumstances delineated, excluding all others. Most essentially, it is in light of these Principles that the state both conceptualises and operationalises the medico-legal category of ‘the already dying’, though it remains the case that there is no clearly established logical link between the articulated Principles and other aspects of the VAD Act, including the eligibility criteria.

Interestingly, while considered morally consistent with the values of Victoria, it was also seen as important that access to VAD be limited in strict ways. Notably, VAD in Victoria does not entail a right to die—as we have emphasised throughout, there is no guaranteed access to VAD. In its deliberations, the Committee determined that the state “should not establish an unencumbered *right* to assisted dying” (2016, 214, our emphasis) and there “should be no presumption of access to assisted dying” (2016, 214). Rather, the Committee advocated for an approach to VAD that serves to “make the practice legal if all criteria are met” (2016, 214), suggesting the option of VAD “should be made available to those who request it and meet all the relevant criteria” (214). The eligibility criteria are accordingly central to the Committee’s expression of the circumstances under which access to VAD is considered reasonable by the state. Thus, in order to negotiate between the rock of violent suicide under the prohibition of VAD and the hard place of unfettered access to VAD through a ‘right to die’, the Victorian government relies on the medico-legal category of *the already dying*.

Second, it is important to recognise that VAD is understood as entirely delimited by and operating within the medical sphere. The original definition of ‘assisted dying’ adopted by the Committee—“assistance to die provided in a medical context” (2016, 14)—inherently embeds features of medicine in the composition of VAD. Proceeding from this foundation, VAD is infused with medical goals and norms, including existing power relations between medical practitioners and patients. In particular, the outcome of VAD—that is, death—ought to be considered beneficent or at least non-maleficent for the patient in their particular circumstance. Further, doctors are empowered to filter between cases based on medicalised interpretations of an additional series of subjective and fluctuating characteristics, such as the *enduringness* of a person’s request for assistance to die. While not part of the explicit eligibility criteria, an assessment of ‘enduringness’ is required as part of the stringent assessments by medical practitioners detailed in the Act (Schedule 1). In effect, as determined by medical practitioners and ultimately the state, the non-dying in their entirety, and some of the already dying, will not have access to medical assistance to die. In short, the category of the already dying is intrinsically related to the medical context in which VAD is permitted, since it requires a medical determination that one is *already dying* and indeed, sufficiently close to death to be eligible. Only those persons medically understood to be ‘dying anyway’ are permitted access to VAD. In this

sense, and despite its explicit intention, VAD is understood as merely hastening death, not causing it as such.<sup>iv</sup>

Third, in this, the Victorian model for VAD gives rise to a paradox of autonomy. While much of the discussion around instituting VAD emphasised patient choice and autonomy—that VAD “provides a safe legal framework for people who are suffering and dying to choose the manner and timing of their death” (State of Victoria Department of Health and Human Services n.d.)—the extent to which choice and autonomy are supported by the legislation is limited. Despite the state’s model of VAD emphasising the voluntariness of the patient as previously discussed, enacting patient ‘choice’ in VAD is wholly contingent on the participation and approval of medical practitioners and ultimately the state (Hempton Manuscript under review [copy on file with author]). Rather than returning the decision to die to the sphere of ‘self-determination’, VAD cements medical control over the decision to die. As Tania Salem puts it, “people will have [VAD] not only because they want it, but because physicians agree they can have it” (Salem 1999, 35). In the model adopted in Victoria, medical practitioners come to function as gatekeepers of assisted death.

## V. Conclusion

In an historic change of ethical and political significance, Victoria has become the first state in Australia to permit medical practitioners to intentionally cause a person’s death. This new practice, termed ‘voluntary assisted dying’, is regulated by the *Voluntary Assisted Dying Act 2017 (Vic)*. In this paper we have established how, in conceiving VAD exclusively for those medically prognosed to die “within weeks or months” (s 9), the state constructs the bounds of a new medico-legal category that we term *the already dying*. As demonstrated, this category of the already dying functions both as the state’s justification for the introduction of VAD, and is further deployed in the operationalisation of VAD as part of regulated medical care. In effect, the categorisation of ‘the already dying’ serves to negotiate a path between the perceived problem of violent suicide on the one hand, and unrestricted access to medically-assisted death on the other. Furthermore, the medical circumscription of access to VAD means that the emphasis on voluntariness is somewhat misleading. The VAD Act limits access to the ‘good death’ of VAD to those determined to be *the already dying*—and dying from a disease that is also causing subjective suffering—but does little to expand the range of self-determination at the end of life for anyone else.

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## Legislation

*Crimes Act 1958* (Vic)

*Charter of Human Rights and Responsibilities Act 2016* (Vic)

*Euthanasia Laws Act 1997* (Cth)

*Medical Treatment Planning and Decisions Act 2016* (Vic)

*Mental Health Act 2014* (Vic)

*Rights of the Terminally Ill Act 1995* (NT)

*Voluntary Assisted Dying Act 2017* (Vic)

*Voluntary Assisted Dying Bill 2017* (Vic)

*Voluntary Assisted Dying Act 2019* (WA)

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<sup>i</sup> One thousand and thirty-seven written submissions were made to the Inquiry; 925 from individuals and 112 from organisations. Further details regarding the public submissions are outlined in the Committee's final report (see VLC LSIC 2016).

<sup>ii</sup> The Panel identified seven rights elaborated in the charter that it considered particularly relevant to VAD, namely the rights to (1) equality, (2) life, (3) protection from torture and cruel, inhuman, or degrading treatment, (4) privacy and reputation, (5) freedom of thought, conscience, religion, and belief, (6) protection of the best interests of the child, and (7) liberty and the security of person" (State of Victoria Department of Health and Human Services 2017a, 43, 210-215).

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<sup>iii</sup> The Northern Territory was the first jurisdiction in the world to introduce legislation to provide for medically-assisted death. The *Rights of the Terminally Ill Act 1995* (NT) was in effect briefly (1 July 1996 to 27 March 1997) before the commonwealth government passed the *Euthanasia Laws Act 1997* (Cth), which in effect prohibits Australian territories (Australian Capital Territory, Norfolk Island, and the Northern Territory) from permitting ‘euthanasia’. Significantly, though, the states of Australia (Queensland, New South Wales, Victoria, Tasmania, South Australia and Western Australia) are not bound by the *Euthanasia Laws Act 1997* (Cth), and retain the authority to independently permit the practice of ‘euthanasia’. At the time of writing, various jurisdictions across Australia are considering the issue of VAD, with many following a similar process to Victoria (i.e. beginning with a state-level inquiry into ‘end of life choices’). Most definitively, following an inquiry (Parliament of Western Australia Joint Select Committee on End of Life Choices 2019) and subsequent Ministerial Expert Panel on Voluntary Assisted Dying (2019), the state government in Western Australia passed the *Voluntary Assisted Dying Act 2019* (WA), which will come into effect in approximately mid-2021.

<sup>iv</sup> In cases of death by means of VAD, the ‘cause of death’ will be registered as the underlying disease—VAD will be recorded as the ‘manner of death’, but not the cause (State of Victoria Department of Health and Human Services 2019).