

29 August 2025

Dear Committee,

I am writing to you in objection of Voluntary Assisted Dying (VAD) being legalized in the Northern Territory. Some of my key concerns with the introduction of this legislation are:

- The 'voluntary' nature of VAD. It seems that the quickest way to make something compulsory in today's world is to label it 'voluntary' at the start. This was demonstrated by the rollout of the COVID-19 vaccination program (particularly in the Northern Territory) and can be seen in effect at present with the introduction of Digital ID in Australia. It is already evident that 'voluntary' uptake quickly becomes 'voluntary or be excluded' (from a particular service or entitlement) to coercive enforcement, then mandatory with severe penalties including social exclusion, economic segregation and loss of freedoms. Based on this common-place approach, 'Voluntary Assisted Dying' may quickly become 'Mandatory Assisted Dying', particularly if it is seen to be for 'the common good'.
- From an economic perspective, other end-of-life options are likely to be overlooked as a result of VAD becoming an option. The ongoing costs of continuing treatment and palliative care will be higher than facilitating the death of a person, making the latter a more attractive 'business model' for those who are responsible for funding (both agencies and families). There are already examples of this occurring in Canada, where patients are more readily offered (pressured towards) assisted dying rather than other treatment options. This may also result in less options for end-of-life care, if the resourcing of VAD alternatives decreases due to the introduction of VAD.
- The social and cultural landscape of the Northern Territory – the significant proportion of the population in rural and remote areas and the high percentage of Aboriginal and Torres Strait Islander people – means that a high proportion of the Territory's population is already isolated and/or vulnerable. Not only geographically but also socio-economically, educationally, and person-to-person contact. This isolation and vulnerability increases a person's susceptibility to being coerced and pressured into 'volunteering' for VAD at the behest of others, without necessarily being able to access ample resources, information and points of view that may otherwise influence their decision.
- The very concept of 'assisted dying' is being impressed upon people already vulnerable (being in a state of suffering or reduced quality of life) and prone to manipulation and coercion. Every person can relate to a time in their lives when they felt hopeless and defeated, whether as a result of illness, trauma, depression, anxiety, emotional turmoil, or some other reason. As a result, we all know from our own experience that such a state of mind increases our susceptibility to finding a 'quick fix', yet in nearly all cases, these challenging times are overcome. For those of whom VAD may be an option, there is an even greater degree of susceptibility and vulnerability given the seriousness of person's circumstances at that time, and likelihood of being coerced/manipulated into dying rather than pursuing other possible treatments or options.
- The conditions of eligibility (such as competence to consent) are likely to be selective rather than comprehensive, as is already the case with many health industry practices (such as determining brain death in a patient).

- The eligibility criteria of ‘no available treatment to effect a cure’ can never be definitive, and is wholly subjective. No available treatment at a given time does not mean that an effective treatment will not become available – research and technological advances are taking place in the health care industry at an unprecedented rate. Many conditions considered untreatable only 5 or 10 years ago, are now being managed. Ending a person’s life on the basis of no available treatment at the time, robs them of the possibility of future treatment.
- Further, how is ‘no available treatment’ being determined? Is this based on professional opinion or is it based on the individual’s uptake of alternative treatments without success? Will ‘available treatments’ consider the availability of other treatments accepted in other jurisdictions/countries, as well as other options that may be considered alternative or experimental – how comprehensive will this list be and on what bases will the list be established?
- The protections for Doctors’ who choose to refuse assistance in relation to VAD. It was demonstrated during the rollout of the COVID-19 vaccination program that Doctors who chose to provide their patients with medical advice appropriate to the patients’ health conditions and circumstances, though contrary to the Government’s mandate, were severely punished. Conversely, despite assurances being provided to Doctors in Australia that they would be protected for administering the experimental COVID-19 vaccinations, there are now numerous court cases taking place against Doctors who were under the belief they were protected. In the case of VAD, how well will Doctors be protected, not only those who refuse to participate in VAD but also those who chose to assist?

I am strongly opposed to VAD being legalized in the Northern Territory. I do not believe that it provides individuals with the due care, respect, and compassion that should be afforded to each person at end-of-life but rather offers a quick and easy (shove it under the carpet) approach at the expense of those who are among the most vulnerable in our community. Further, I believe the introduction of the legislation – though as ‘well intentioned’ as it may appear – will provide a foundation for personal rights and freedoms to be violated at the behest of others. I implore the Committee, and the Northern Territory Government, reject *Voluntary Assisted Dying in the Northern Territory*.

Kind regards,

██████████ (Please withhold my name and contact information from public release)

██████████