Submission to the Northern Territory's Parliamentary Inquiry into 'Voluntary Assisted Dying'
AUGUST 2025

Pro-Life Victoria (Inc.) (PLV) appreciates the opportunity to provide a submission to the Parliamentary Inquiry into Voluntary Assisted Dying (VAD). This submission is an additional body of work to our submission to the Northern Territory government on the same subject in 2024. While not based in the Northern Territory, we have a number of supporters and friends in the Territory who share our weighty concerns- we write this submission on their behalf.

Opening comments

Voluntary Assisted Dying (VAD) is a very dangerous practice to legalise. While there is clearly pressure from some within the Northern Territory to legalise it, there is still significant opposition to the practices of euthanasia and assisted suicide. Your own survey found that 39% of survey respondents disagree with legalising this practice (and only 52% agree and 9% neither agree nor disagree).[1]

It is our position that any law permitting assisted suicide or euthanasia is inherently unsafe and unjust. We support the approach set out by the Australian Care Alliance, who advocate working towards a society where assisted suicide and euthanasia are *unthinkable* because:

- all have access to best practice palliative care, through wider dissemination of palliative care skills and knowledge among health practitioners and better integration of palliative care in all health services;
- people with disability have equitable access to health care and are supported to live their lives to the full as valued members of the community;
- suicide prevention strategies and services offer hope to any person with suicidal ideation, including those with declining physical health; and
- the elderly are protected from all forms of elder abuse, including any pressure to see themselves as an unwanted burden.

We answer some questions from the Consultation Paper below. We also welcome the opportunity to attend, alongside our supporters in the Northern Territory, any hearings which you conduct on the potential for legislation of a VAD regime.

Do you support making VAD legal in the NT?

No.

All forms of legalised assistance of suicide and euthanasia are dangerous and fundamentally degrade the value of a human being's life to a mere function of health or/and ability. This is a slippery slope that has no

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[1] *Northern Territory Government, commissioning body. (2024). Report into Voluntary Assisted Dying in the Northern Territory: Final Report 2024, p. 25 (survey results, row 3). Northern Territory Government, Darwin.*

end – indeed, the Netherlands now allows euthanasia for babies and little children who have no way of giving consent.

Legalising assistance of suicide and euthanasia through the implementation of a VAD regime also turns the collective profession of doctors from healers to killers – many against their own conscience. It also makes governments complicit with the promotion and execution of suicide, which is a dangerous message to a community already plagued with the scourge of suicide particularly within its indigenous community[2].

Unique to the Territory, is the significant Indigenous population who already experience a lower life expectancy and poorer access to health care compared to their non-Indigenous counterparts. The implementation of a VAD regime would arguably undermine attempts to close this significant gap. The voices of Indigenous Australians living within the Northern Territory should be considered closely in this process.

Below we set out the main points of our opposition in detail:

1. VAD poses a disproportionate risk to Indigenous Australians

It is well known that the life expectancy of Indigenous Australian's is far lower than non-indigenous Australians, so too the incidence of largely preventable diseases and the suicide rate – with an alarming suicide rate about 2.7 times higher than non-indigenous Australians[3]. Specific vulnerabilities and many disadvantages cannot be ignored in the life and death decision to legalise assisting suicide and euthanasia.

After the Northern Territory's *Rights of the Terminally Ill Act 1995 (ROTI Act)* was overturned, a prominent and respected Aboriginal rights activist, journalist and artist, Chips Mackinolty, wrote an article titled *"Euthanasia Right Legislation: Wrong jurisdiction?"* which was published in the Alternative Law Journal[4]. His article specifically looked at the dire effects that euthanasia and assisted suicide would have on the Indigenous people of the Northern Territory in terms of poorer health outcomes and how such a law was tone-deaf to aboriginal culture and philosophies. Mackinolty is an open supporter of euthanasia but mounted a strong case for why euthanasia and assisted suicide are wrong for Aboriginal residents and therefore it's wrong for the Territory.

Mackinolty and his team met with 900 Aboriginal people from approximately 100 communities which was estimated to comprise of about 6% of the adult Aboriginal population of the Northern Territory at the time. Only two of the 900 were supportive of euthanasia and assisted suicide. This led Mackinolty to conclude:

> *"Whether the legislation is good or bad for us, as whitefellas within our own cosmology, is immaterial. I believe the very existence of the legislation poses an unacceptable risk to the health of Aboriginal Territorians who may delay or refuse to access health care because of fears they have of the legislation. Those fears are deeply embedded in Aboriginal world views. Put simply, it has the potential to lead to premature deaths amongst a group of people whose life expectancy is already unacceptably low…. I do believe that there are very real risks to the health of Aboriginal people, by virtue of the existence of the legislation: it's what people believe about the legislation, not what may actually be*

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[2] Australian Institute of Health and Welfare (no date) *Self-harm and suicide monitoring: First Nations people*, Australian Institute of Health and Welfare website. Available at: https://www.aihw.gov.au/suicide-self-harm-monitoring/population-groups/first-nations-people

[3] Ibid

[4] Mackinolty, C. (1997) 'Euthanasia Right Legislation: Wrong jurisdiction?', *Alternative Law Journal*, 22(2), pp. 68–71. Available at: http://www.austlii.edu.au/au/journals/AltLawJl/1997/26.pdf

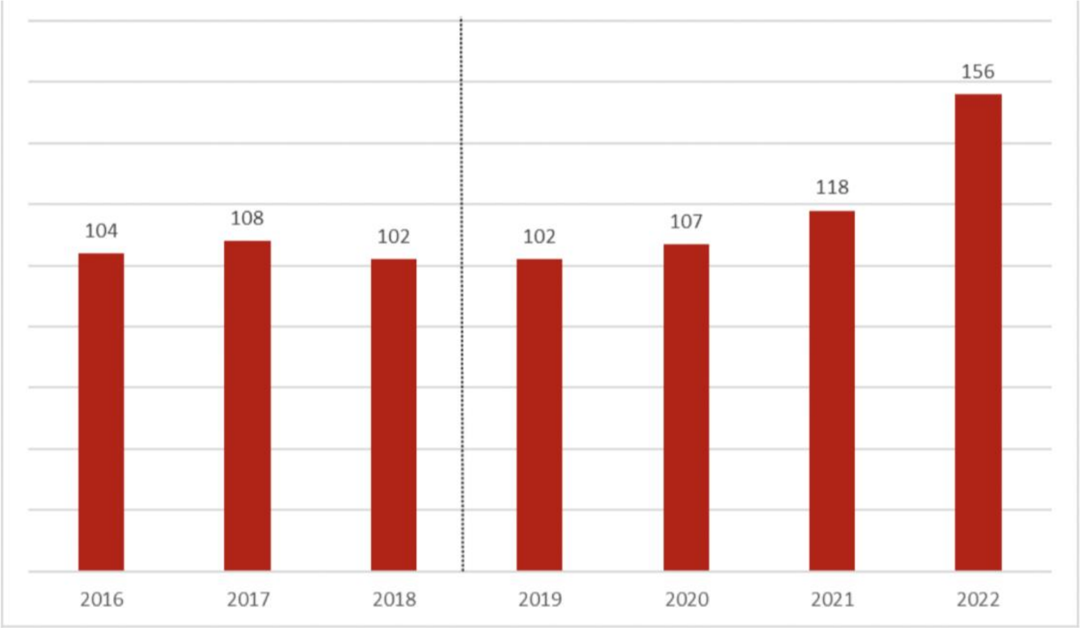
> *contained within it. Frankly, I do not think Aboriginal people need another potential 'agency', let alone 'cause', of death."* [5]

We argue that these critical observations by Mackinolty and the indignant sentiments the vast majority of indigenous people hold towards assisted suicide and euthanasia would remain unchanged today and must be appropriately weighed in this committee's considerations. (See Appendix I for full copy of this paper).

2. When legalised, VAD causes the social contagion of suicide

Both unexpected and tragic is the social contagion of suicide that follows the legalisation of a VAD regime. As Victorian's we first speak from the sad Victorian experience. At the time of the Parliamentary debate on Victoria's *Voluntary Assisted Dying Bill (2017)* proponents often cited that terminally ill Victorians were dying by suicide at the rate of 'one a week', with the clear message that a change in the law could help prevent up to 50 unassisted suicides a year.[6] This argument, first given by the Victorian Coroner, gained such traction it was used in 18 out of the 25 Parliamentary speeches for the legislation, including the then Premier, Daniel Andrews. Indeed, a seeming goal of the reduction in suicides amongst the ill and elderly became one of the main and foundational suppositions for passing the legislation. However, there has been over *50% more unassisted suicides* amongst the over 65s between 2019 (NB: the law came into effect in June 2019) and 2022. In 2019 there were 102 unassisted suicides and in 2022 there were 156. The below graph[7]shows the unassisted suicide rates in Victoria for the over 65s age group for the years 2016-2022.

Table 1: Unassisted suicide in Victoria for people 65 or over



Data for years 2018 to 2022 taken from the Coroners Court Monthly Suicide Data Report December 2022 (Coroners Court of Victoria, 2023); data for years 2016 and 2017 taken from the Coroners Court Monthly Suicide Data Report December 2020 (Coroners Court of Victoria, 2021).

Jones (2023) observed: *"Between 2018 and 2022, the increase was 54 elderly suicides. Rather than a reduction of "at least one suicide every week", there has been an unwelcome increase of approximately one*

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[5] Mackinolty, C. (1997) 'Euthanasia Right Legislation: Wrong jurisdiction?', *Alternative Law Journal*, 22(2), pp. 68–71. Available at: http://www.austlii.edu.au/au/journals/AltLawJl/1997/26.pdf

[6] Jones, D.A. (2023) 'Did the *Voluntary Assisted Dying Act 2017* prevent "at least one suicide every week"?', *Journal of Ethics in Mental Health*, Open Volume (2023), p. 2. Available at: https://jemh.ca/issues/open/documents/Did%20the%20Voluntary%20Assisted%20Dying%20Act%202017.pdf

[7] Ibid, page 10

[unassisted] suicide a week.”. This is clear evidence of the social contagion of suicide linked to the implementation of a VAD regime.

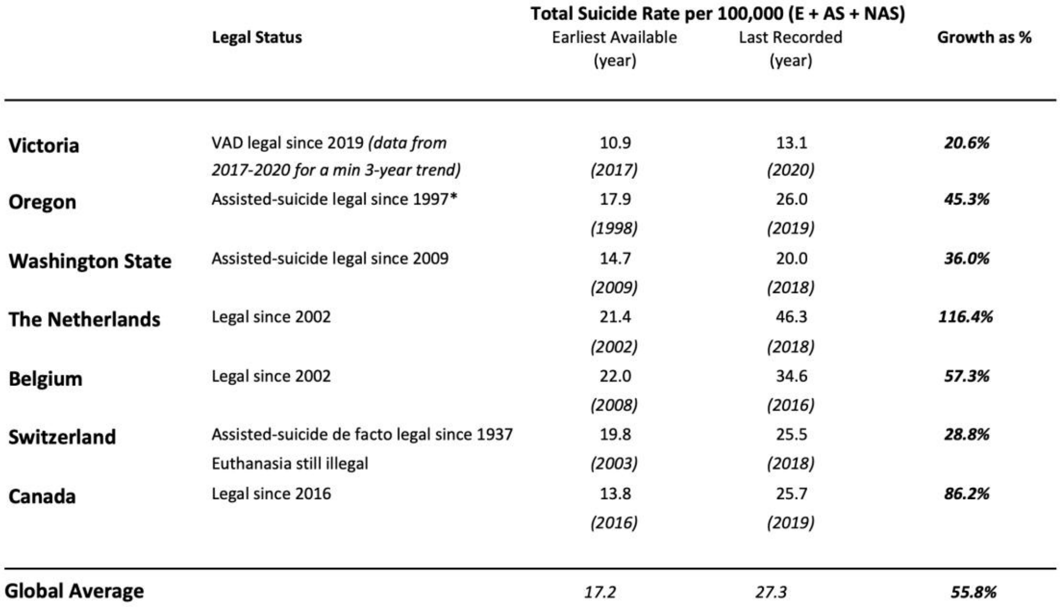
Australian Care Alliance have also recorded the evidence of social contagion of suicide in Victoria since the VAD regime came into effect. They state:

> *“.. according to the Coroners Court of Victoria there were 694 deaths by suicide in Victoria in 2017. There were slightly more - 698 - in 2020, which was the first full calendar year in which State issued suicide permits and the State-funded poison delivery service were in operation. So there is no evidence that the anticipated decrease of 50 deaths by (non-authorised) [unassisted] suicide each year has been achieved… the total [suicide, so euthanasia &/or assisted suicide +* ***un****assisted suicide] for 2020 would be 873 - a 25.8% rise since 2017”*[8].

Further, the state of Oregon implemented a VAD regime in 1997 which has led to a steady increase in unassisted suicide rates. In 2012 Oregon’s suicide rate was 42% higher than the US national average. Alarmingly, the Oregon government’s own website reports that “[s]uicide is one of the leading causes of death in Oregon.”[9]

Research undertaken by *Cherish Life Queensland*[10] in 2021 analysed the total suicides (ie, including euthanasia and/ or assisted suicides plus recorded unassisted suicide rates) in seven jurisdictions that had implemented a VAD regime (see summary table below). *The average increase in total suicides for the seven jurisdictions was 55.8% since implementation of VAD demonstrating clear evidence of contagion of suicide.* A full copy of this analysis can be found on the Queensland Governments website here.

Table 2: Total suicides across jurisdictions where VAD regimes have been implemented



	Legal Status	**Total Suicide Rate per 100,000 (E + AS + NAS)** Earliest Available (year)	Last Recorded (year)	**Growth as %**
Victoria	VAD legal since 2019 *(data from 2017-2020 for a min 3-year trend)*	10.9 *(2017)*	13.1 *(2020)*	***20.6%***
Oregon	Assisted-suicide legal since 1997*	17.9 *(1998)*	26.0 *(2019)*	***45.3%***
Washington State	Assisted-suicide legal since 2009	14.7 *(2009)*	20.0 *(2018)*	***36.0%***
The Netherlands	Legal since 2002	21.4 *(2002)*	46.3 *(2018)*	***116.4%***
Belgium	Legal since 2002	22.0 *(2008)*	34.6 *(2016)*	***57.3%***
Switzerland	Assisted-suicide de facto legal since 1937 Euthanasia still illegal	19.8 *(2003)*	25.5 *(2018)*	***28.8%***
Canada	Legal since 2016	13.8 *(2016)*	25.7 *(2019)*	***86.2%***
Global Average		*17.2*	*27.3*	***55.8%***

Key: E =euthanasia AS = assisted suicide NAS = non-assisted suicide.

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[8] Australian Care Alliance (no date) ‘Wrongful deaths by suicide or euthanasia’, *Australian Care Alliance* factsheet. Available at: https://www.australiancarealliance.org.au/wrongful_categories.

[9] Oregon Health Authority (no date) *Oregon Violent Death Reporting System*, Oregon government website. Available at: https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/INJURYFATALITYDATA/Pages/nvdrs.aspx.

[10] Cherish Life. (2021). “Submission to Queensland Parliament’s Health and Environment Committee regarding the Voluntary Assisted Dying Bill 2021”. *Queensland Parliament*. Available at: https://documents.parliament.qld.gov.au/com/HEC-B5E1/VADB2021-DBF8/submissions/00001309.pdf.

3. There is strong opposition from Doctors to VAD regimes

An overwhelming number of medical doctors in Australia, and around the world, are strongly opposed to euthanasia and assisted suicide. We assert that their highly educated and clinical opinion should far outweigh the cries of the suicide lobby which is often led people with no medical training but with a profile that attracts media attention.

The Australian Medical Association (AMA) – the peak medical body in Australia – published a position statement on Euthanasia and Assisted Suicide which states:

> *"The AMA believes that doctors should not be involved in interventions that have as their primary intention the ending of a person's life. This does not include the discontinuation of treatments that are of no medical benefit to a dying patient,"*[11]

The World Medical Association (WMA) has also stated their opposition to euthanasia and physician assisted suicide:

> *"The WMA reiterates its strong commitment to the principles of medical ethics and that utmost respect has to be maintained for human life. Therefore, the WMA is firmly opposed to euthanasia and physician-assisted suicide……No physician should be forced to participate in euthanasia or assisted suicide, nor should any physician be obliged to make referral decisions to this end,"*[12]

In 2017, 101 Australian Oncologists in 2017 wrote a letter of strong opposition to euthanasia and assisted suicide laws the Victorian government were considering. An excerpt from their letter is here, and a full copy is included in Appendix I:

> *"As 80% of those who access physician assisted dying legally overseas have cancer, we feel our perspective on this issue should be heard….We collectively represent a significant proportion of the oncology workforce in the state of Victoria…. Physician assisted death is not, by definition, medical treatment. It is not palliative care. We as doctors and medical specialists do not want to intentionally end the lives of our patients, or provide them with the direct means to do so. Assisted suicide is in conflict with the basic ethical principles and integrity of medical practice and undermines trust in the medical profession. We strive to eliminate suffering but not the sufferers themselves,"*[13]

Similarly, over 100 Australian palliative care specialists, signed an open letter condemning euthanasia and assisted suicide, as well as seeking to educate people on the excellent work that palliative care medicine can do. Many others doctors have voiced their concerns and we hope that their voices will be listened to through this submission process. In summary, medical professionals within Australia and across the world are opposed to the implementation of VAD regimes.

4. Wrongful deaths as a result of VAD regimes

There are always going to be casualties of people dying under a VAD regime who should not have under that jurisdiction. Even in jurisdictions which boast that they have "safeguards" and strict barriers to access enshrined in their laws and policies, these extra casualties – which are wrongful deaths – still occur. For

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[11] Australian Medical Association (2016) *Position Statement on Euthanasia and Physician Assisted Suicide*, Australian Medical Association website. Available at: https://www.ama.com.au/sites/default/files/documents/AMA_Position_Statement_on_Euthanasia_and_Physician_Assisted_Suicide_2016.pdf

[12] World Medical Association, World Medical Association (2021) *WMA Declaration on Euthanasia and Physician-Assisted Suicide*, World Medical Association website, 23 November 2021. Available at: https://www.wma.net/policies-post/declaration-on-euthanasia-and-physician-assisted-suicide/

[13] Victorian Oncologists (101) (2017) *Open letter from 101 Victorian oncologists to the Victorian Government: request to oppose the Voluntary Assisted Dying Bill 2017*, 19 September.

example, in Queensland where a VAD regime has only been in effect since 1 January 2023 there have already been two recorded cases of men taking their partners VAD medication:

1. In 2023, a man died after ingesting his late wife's VAD medication which had been sent to the family home for her. The Coroner's inquest into the man's death found the laws had failed to find a balance between a patient's autonomy and lethal medication safety[14].
2. In May 2025, a man, after his partner had just died by VAD at Gold Coast University Hospital, ingested some of her VAD medication while at the hospital – which almost killed him and he had to be resuscitated.[15]

Australian Care Alliance has a massive body of work on wrongful deaths – for the committee's benefit, we suggest you refer to their website https://www.australiancarealliance.org.au/wrongful_categories

In summary, VAD regimes can never be made safe, ever. The safest and most humane thing a government can do to help people at the end of life is invest in palliative care.

5. VAD regimes are inevitably extended

While evidence shows that so called safeguards are misleading in name and VAD is anything but safe, evidence also shows that over time, initial "safeguards" are often corroded or completely done away with. As eligibility to access broadens – referred to as the "slippery slope" – so too does the number of people who access it to that nation's own detriment. Victoria is currently reviewing its VAD regime with the view of remove 'safeguards' which were used to argue for its initial legislation.

When legalised assisted suicide and euthanasia was introduced in 2016 in Canada it was for a "grievous and irremediable medical condition", whose "natural death was reasonably foreseeable". Suicide lobby groups slammed the legislation for being "too restrictive" and the law was changed in 2021 to allow access for those with "grievous and irremediable" mental illnesses[16].

Now some doctors are alarmingly instigating euthanasia and assisted suicide discussions with Canadians with depression and disabilities. In 2021, an army veteran seeking treatment for post-traumatic stress disorder and a traumatic brain injury was rightly outraged to be offered assisted suicide, entirely unprompted"[17]. There is also a push by the euthanasia lobby in Canada to extend their version of VAD to dementia patients who have no real way of giving consent[18].

The Netherlands was the first nation to legalise euthanasia and assisted suicide in 2002. This regime has been significantly expanded access over the years. In addition to children over 12 being able to access it, in 2020 babies and children up to 12 years old, who have no way of giving consent can now be euthanised with parental consent[19] . In 2021, six babies aged less than one year old with congenital anomalies were little

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[14] Callinan, R. (2025) 'Man almost dies after allegedly taking partner's VAD drugs at Gold Coast University Hospital', *ABC News*, 29 May. Available at: https://www.abc.net.au/news/2025-05-29/gold-coast-voluntary-assisted-dying-investigation/105349138

[15] Ibid

[16] Bryden, J. (2021) 'Senate passes Bill C-7 to expand access to medical assistance in dying', *CBC News*, 17 March. Available at: https://www.cbc.ca/news/politics/senate-passes-medical-assistance-dying-billc7-1.5954281.

[17] Yuill, K. (2022) 'How Canada became a world leader in euthanasia', *Spiked*, 26 October. Available at: https://www.spiked-online.com/2022/10/26/how-canada-became-a-world-leader-in-euthanasia/.

[18] Wittenberg-Cox, A. (2022) 'Slippery slope or wise demise? The pros and cons of medically assisted dying', *Forbes*, 1 November. Available at: https://www.forbes.com/sites/avivahwittenbergcox/2022/11/01/slippery-slope-or-wise-demise-the-pros-and-cons-of-medically-assisted-dying/.

[19] BBC News. (2020) 'Netherlands backs euthanasia for terminally ill children under-12', *BBC News*, 14 October. Available at: https://www.bbc.com/news/world-europe-54538288.

victims of euthanasia in The Netherlands' – they were killed intentionally by the administration of lethal drugs[20]. In 2023 there were 20 children between 12 and 17 years who died by euthanasia or assisted suicide.

In our home state of Victoria, the push to expand the VAD regime to include dementia patients is real and seems relentless[21] People suffering from dementia categorically do not have capacity to make such a massive and final decision as opting for euthanasia or assisted suicide. This serves as a warning.

6. People who are dying deserve the right to gold-class Palliative Care services

Our concerns regarding palliative care are three-fold. Firstly, evidence shows that many people at the end of life have not accessed palliative care – this is a great shame as it is a speciality and gold standard for end-of-life care, taking a comprehensive and holistic view to patient care. Secondly, the presence of a VAD regime of any kind "competes" with palliative care. Thirdly, palliative care deficiencies in a jurisdiction, can lead to needless suffering at the end of life. Put simply a poorly resourced or inequitable health care system can lead to a search for "short cut" solutions like euthanasia or assisted suicide as people suffer needlessly.

In a nation first study, a Melbourne psychiatrist studied all suicide deaths reported to the Coroner Court of Victoria between 2009 and 2013 of those with "active, diagnosed cancer". Out of the 2,870 suicides in Victoria over that period, 118 of the deceased were included in the study having met the criteria as having known active (not in remission) cancer at the time of death (as confirmed via the Victorian Suicide Register - VSR). Of those it found that only 13% of the deceased cancer patients (15/118) had documented evidence of engagement with a palliative care service[22].

The study stated:

> *"The low levels of Palliative Care access among those with a probable cancer-suicide correlate (13%) despite at least one third having metastatic disease (34%), and almost half (42%) having pain are in keeping with other published findings suggesting late or even absent referral to palliative care despite documented benefits for patients with cancer… In the meantime, our findings suggest referral to a Palliative Care service as key part of the initial response to a patient with cancer, significant symptoms, and suicide intention."*[23]

Palliative care services are also often holistic and can help a patient with feelings of hopelessness or/and sadness because of a diagnosis or prognosis. They can often arrange for mental health services and specialists for patients who need this type of help. Indeed, research into the characteristics of cancer patients who died by (unassisted) suicide in Victoria led a Victorian physiatrist Dr Justin Dwyer and peers to recommend that:

> *"All clinicians working with cancer patients should be prepared to explore suicidal ideation. Understanding how the patient conceptualises suicidality with respect to cancer experience and mental health may be of central importance in determining whether mental health care is best provided as part of cancer care, or through a separate mental health service*."[24]

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[20] Statistics Netherlands (CBS). (2023) "Deaths by end-of-life decision, age, cause of death", The Netherlands. *StatLine*. Available at: https://opendata.cbs.nl/statline/#/CBS/en/dataset/81655ENG/table.

[21] Komesaroff, P.A., Chapman, M., Lamba, G., Kerridge, I.H., Stewart, C.L., Holmes, A., Lewis, S. and Philip, J. (2024) 'Should voluntary assisted dying in Victoria be extended to encompass people with dementia?', *The Medical Journal of Australia*, 220(9). doi: 10.5694/mja2.52273. Available at: https://www.mja.com.au/journal/2024/220/9/should-voluntary-assisted-dying-victoria-be-extended-encompass-people-dementia#6.

[22] Dwyer, J., Hiscock, R., et al. (n.d.) 'Characteristics of patients with cancer who die by suicide: Coronial case series in an Australian state'.

[23] Ibid

[24] Dwyer, J., Hiscock, R., Ravi, A., Freeman, S., & Winship, I. (2019) 'Characteristics of patients with cancer who die by suicide: Coronial case series in an Australian state', *Psycho-Oncology*, 28, pp. 219

Brief answers to additional questions:

Should health professionals be required to provide information on palliative care options if a person requests VAD?

Yes, palliative care should always be the first information people in this situation receive. In the regrettably scenario that a VAD regime is legalised, palliative should be the option that the Northern Territory government prefers, protects and elevates in funding, legislation, policy and clinical guidelines.

If a health practitioner declines to be involved in a person's request for VAD, should they be required to take any particular action/s? If so, what action/s? For example, passing on information to a centralised VAD service.

None. As outline above, many doctors are opposed to VAD regimes and should not be required to be involved either passively or assertively in the promotion of the regime. Everyone, without exception, should have the right to full conscientious objection. Compelling doctors to refer for VAD against their own conscience, is not only unethical, but it will likely contribute to further medical staff shortages. It's worth noting that the Australian Medical Association supports a doctors' right to have a full conscientious objection to euthanasia and assisted suicide in jurisdictions where it is legalised, and the establishment of regulations and laws to protect these doctors[25].

Doctor initiated discussions: Should health practitioner be free to initiate a discussion about VAD, providing information alongside other treatment and management options such as palliative care? What other treatment options should be discussed?

No, never.

An "option" can feel like a suggestion (or even subtle coercion) when someone is sick, alone, worried about the future and grieved by their diagnosis and prognosis.

There is an inherent power imbalance in the doctor-patient relationship. The doctor is the one with the medical knowledge and the authority to prescribe medication or order other treatment. People are usually feeling unwell and vulnerable when they go to the doctor – that's why they go – how much more so in the face of a terminal diagnosis or a crushing prognosis. Many look to their doctors at these times for answers and even hope. Having a doctor raise VAD at such a time could be utterly crushing and the opposite of good healthcare.

Palliative Care: Should health professionals be required to provide information on palliative care options if a person requests VAD?

Yes, if, regrettably a VAD regime is legalised, the right to palliative care must be enshrined in law by the Northern Territory Government. Everyone should be given information on palliative care and ideally have at least two government funded (ie free) in person consultations with a palliative care specialist or specialist team. This will help ensure they are getting best holistic end-of-life care and that symptoms are being adequately managed with the most up to date medical methods. A study in Victoria revealed that only about

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[25] Australian Medical Association (AMA). (2016) "Position Statement on Euthanasia and Physician Assisted Suicide". *Australian Medical Association*. Available at: https://www.ama.com.au/sites/default/files/documents/AMA_Position_Statement_on_Euthanasia_and_Physician_Assisted_Suicide_2016.pdf.

13% of cancer patients who died by suicide had accessed palliative care, this is terrible. Every Australian should have the right to access free palliative care at the end of life.

Death certificate: What should be recorded as the cause and manner of death for a person who has died by accessing VAD?

For the sake of truth and for the purposes of longitudinal data collection– whether the patient died of euthanasia or assisted suicide should be recorded on the death certificate.

Summary

This submission outlines our serious concerns about the potential medium- to long-term effects of legalising Voluntary Assisted Dying (VAD) in the Northern Territory, based on experiences from other jurisdictions and the Northern Territory's unique challenges. Key concerns include:

- *Medical workforce impacts*:

  Fewer doctors may choose to work in the Northern Territory, with greater difficulty in attracting and retaining new medical professionals. A decline in faith-based entrants to medicine may also affect doctor-per-capita ratios.

- *Indigenous health*:

  Fear of the VAD regime may lead Indigenous Australians to further avoid mainstream medical care, potentially worsening already low life expectancy.

- *Mental health and suicide*:

  Enacting a VAD regime will contribute to increased suicide rates through social contagion, particularly by members of vulnerable communities. Families and people with disabilities may also experience worsened mental health outcomes.

- *Palliative care*:

  Supporting this legalisation could reduce long-term investment in palliative care, especially in rural and remote areas, and disincentivise innovation in pain relief.

- *Doctor-patient relationship*:

  Concerns are raised about shifting perceptions of doctors from healers to participants in ending life.

- *Elder abuse and coercion*:

  There may be increased risks of elderly abuse and pressure to choose euthanasia or assisted suicide, including due to financial motives.

- *Slippery slope*:

  As difficult end-of-life cases arise, safeguards will be eroded over time.

In summary, legalising a VAD regime in the Northern Territory could lead to significant negative consequences for the medical system, vulnerable populations, and societal attitudes toward life, death, and care.

Recommendations

Considering the serious concerns regarding the legalisation of Voluntary Assisted Dying (VAD) in the Northern Territory, we make the following recommendations:

1. **No Introduction of VAD Legislation**
   The Northern Territory Government should refrain from drafting or enacting any form of Voluntary Assisted Dying legislation now or in the future.
2. **Rejection of Any Proposed VAD Bill**
   Should a VAD Bill be introduced, we call on Parliamentarians vote it down in its entirety and prevent its enactment.
3. **Conduct a Targeted Medical Survey**
   A comprehensive, solutions-focused survey should be conducted among Northern Territory doctors to gather their views on VAD, current palliative care provision, and broader healthcare challenges specific to the Northern Territory. This should be conducted as a matter of urgency.
4. **Preserve Existing Suicide Prevention Laws**
   The current Northern Territory legislation that criminalises the encouragement or incitement of suicide should remain in full force. It is a just law aimed at protecting lives and must not be repealed or weakened.
5. **Increase Investment in Palliative Care**
   Greater investment is needed in palliative care services across the Northern Territory, including a formal proposal to the Commonwealth Government for additional funding to meet current and future needs.
6. **Ensure Equitable Access to Palliative Care**
   Legislation should be introduced to guarantee that all residents—regardless of geography, background, or means—have equitable access to high-quality palliative care.
7. **Promote Life-Centred Healthcare Initiatives**
   The NT Government should initiate a community consultation process to explore and implement innovative, life-affirming healthcare initiatives. These should aim to improve outcomes for both Indigenous and non-Indigenous communities, while also enhancing the recruitment and retention of healthcare professionals in the Northern Territory.

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Appendix I

Mackinolty, C. (1997) ‘Euthanasia Right Legislation: Wrong jurisdiction?’, *Alternative Law Journal*, 22(2), pp. 68–71. Available at: http://www.austlii.edu.au/au/journals/AltLawJl/1997/26.pdf

Right legislation: Wrong jurisdiction?

Chips Mackinolty

Extract from a written statement to the the Senate Committee on Legal and Constitutional Affairs Inquiry into Euthanasia.

Editor's introduction

The passage of the Euthanasia Laws Act 1997 (Cth) through the Senate was as vivid an illustration of representative democracy at work as we're likely to see for some time in Australia.

The debate and vote were preceded by an inquiry by the Senate Legal and Constitutional Affairs Committee which attracted an unprecedented 12,577 public submissions. The Committee's Report gives particular prominence to the oral evidence of long-time Darwin resident Chips Mackinolty, who had previously been commissioned by the Northern Territory Government to conduct an education program in Aboriginal communities about the Rights of the Terminally Ill Act 1995 (NT) (ROTI).

The program's Aboriginal Steering Committee instructed Mackinolty to record Aboriginal views about the ROTI and relay them to the Government.

Mackinolty and his team proceeded to conduct 21 community meetings across the Territory with some 900 Aboriginal people from approximately 100 communities between June and October 1996. Men and women met separately, and interpreters were used at each meeting. Mackinolty estimates that about 6% of the adult Aboriginal population of the Northern Territory participated directly in the program.

The results were virtually unanimous: every one of the meetings was strongly opposed to the ROTI, and Mackinolty reports that of the 900 participants, only two, in private comments, expressed views supportive of the legislation.

Mackinolty's Senate submission, which is published below, is impressionistic rather than academic in form, but the impression he had received was overwhelming. As a personal supporter of euthanasia, he had some misgivings about disseminating arguments which he knew would be enthusiastically taken up by conservatives as fuel for their campaign against the ROTI. And, indeed, this is precisely what transpired: Mackinolty has attracted criticism in some progressive circles for playing into the hands of the Lyons Forum. But his decision to speak out was driven by a firm belief that the views of the Aboriginal community, whose members comprise a substantial majority of the Territory's permanent population, must be given due and proper weight. • RG

The aim of the education program was to inform Aboriginal people of the nature and content of the ROTI legislation. It was not to 'take sides' on the legislation one way or another, but to inform. Nevertheless, we undertook, as we moved around the Territory, to relay any concerns people had back to Northern Territory Health Services (the department). The major emphasis was on delivery of the program to remote Aboriginal communities, though major centres were also covered.

On taking the contract, the department and myself were of the view that, given appropriate educational delivery and content, people would

Chips Mackinolty is a Northern Territory journalist, researcher and graphic artist.

understand what the legislation was about, and that the fears that had been expressed in some quarters of the media, would be sufficiently allayed such that Aboriginal Territorians would deal with the legislation in much the same way as they do others.

The voluntary nature of the legislation would ensure that people wouldn't fear a law which, by its nature, did not have to be activated unless an individual chose (though the notion of a 'voluntary' law also proves problematic, see below).

At one level, I am confident that among the 800 or so people we spoke to in face to face education sessions, such knowledge was understood at the level of factual, objective information. A number of communities took on further education work among their people at the family/clan/community level; and feedback from many of the sessions was positive in terms of peoples' understandings of the process.

However, for reasons I will explain, I am not convinced that acquiring objective knowledge of the contents of the ROTI legislation had any significant impact on Aboriginal knowledge and perceptions of sickness and health, life and death. For this reason, it is my personal view that the existence of the ROTI legislation presents a continuing threat to the health and wellbeing of many Aboriginal people in the Northern Territory.

Two cosmologies: clashing? — or not meeting at all?

It has been claimed in some quarters that rejection of the legislation can be attributed largely to unscrupulous manipulation on the part of Christian churches operating on Aboriginal communities. The inferences from this seem to be that Aboriginal people either should not have the freedom of choice to embrace Christianity, or that they are too stupid to see through being manipulated. I find both inferences offensive and wholly inaccurate.

I strongly suspect that the Christian churches present on many Aboriginal communities were not as influential and successful on this issue as they might have liked. As noted in my reports to the department, rejection of the ROTI legislation was just as strong on communities not heavily influenced by Christian churches. It is my firm view that it is traditional religion and law that has been the overwhelmingly dominant factor influencing Aboriginal peoples' rejection and fear of the ROTI legislation.

Where Christian views certainly played a part on those communities that have an enduring attachment to one or other of the churches, there is no doubt in my mind that adherence to traditional views about life and death have been the principal motives behind Aboriginal attitudes.

After the program was in place for some weeks, it was my initial view that there were two widely differing world views or cosmologies at play in the debate on euthanasia on Aboriginal communities; and that these two cosmologies were clashing on the issue. Over time, I have come to the conclusion that in fact these two cosmologies just weren't meeting at all.

To put it in basic terms, and I make no apology for oversimplifying very difficult concepts, in Aboriginal cosmology the notion of 'natural' death applies only, perhaps, to the extremely old person. In all other cases, cause of death lies in a complex interplay of sorcery, payback and/or transgression of the law.

Thus, although the 'cause' of death might appear to non-Aboriginal people to result from trauma (e.g. a road accident) or disease (e.g. a heart attack or cancer), Aboriginal people would look beyond such apparent 'causes' to determine whether the person died from sorcery attacks, vengeful spirits, from breaking the Law and so on. In that light, things such as cancer or a vehicle rollover are merely 'agents' by which that person died — not the 'cause'. The nearest thing I can liken it to is a post mortem: on many occasions bodies will be inspected by senior ritual leaders to determine who or what 'caused' or 'made' someone die.

In light of this, the somewhat sensationally publicised fears about 'the euthanasia needle' miss the point, if you'll excuse the expression. It is not the needle as such that people fear, it is the capacity of the 'euthanasia needle' to be used as an agent of death — particularly by sorcerers — that has engendered such universal distrust, and widespread demands that the euthanasia drugs not be kept on communities; that community clinics and staff be prohibited from practising euthanasia; and for the legislation to be repealed.

I know this is a difficult area to understand, dealing as it does with unfamiliar notions such as sorcery, which western 'science' would dismiss — if not ridicule — as superstition. I make no comment about peoples' belief systems suffice to say that such systems are deeply embedded in various world views — Aboriginal and non-Aboriginal — and are an integral part of peoples' lives. Peter Sutton, one of Australia's leading anthropologists, was quoted thus last year:

> Sorcery is one of the most enduring bits of Aboriginal tradition and culture ... It's not just superstition. It's totally integrated with politics and the need for social control. People are not politicising this issue [euthanasia] in the media, they've always politicised death.

So imagine, if you can, the fearful power a sorcerer might wield through the 'agency' of euthanasia: being able to 'make' a white doctor in Darwin, say, kill someone through the 'euthanasia needle'.

The views gathered in the course of the education program emphasize Sutton's statement about the durability of this belief system, and can be found in the literature. For example, Janice Reid, in research carried out in the late 1970s in north eastern Arnhem Land confirmed that there had been no fundamental change in people's attitudes over the 40 odd years since T.T. Webb wrote on the issue in the same general region in the 1930s. Indeed, Reid suggested that traditional attitudes had possibly strengthened over that time as a response to colonialism. The attitudes we found, 60 years later, again in the same region, revealed no diminution in these cultural attitudes to life and death.

So, there is a very simple solution for people to avoid the perceived threat: avoid clinics and hospitals so as to minimise chances of having to confront this new threat in the armoury of the sorcerer.

When this issue was raised by me with the Health Department, they did the only logical 'scientific' thing: they inspected clinic statistics to see if there had been a dropping off of clinic use. As the Northern Territory submission suggests, there has been no lessening of clinic use according to available statistics.

I do not argue this, except to point out that even with the best statistics in the world —and the department has acknowledged elsewhere their figures are not as good as they would like — statistics can only measure what has happened in the past, not what will happen in the future. Furthermore, no matter how good the data collection method is, statistics will not reveal the rates of non-presentation or late presentation, or the extent to which these factors may or may not have affected the course of an illness.

There has been widespread research and anecdotal evidence to suggest a reluctance on the part of many Aboriginal people, many of whom are in high risk categories, to present at clinics or go to hospital — even before the introduction of the ROTI legislation. It makes perfect sense: why go to a place where people die?

Since that time, anecdotal evidence to the effect that people are not presenting, or delaying presentation or treatment, because of fears about euthanasia has been reported to us on many communities; and indeed three deaths 'caused' through the 'agency' of euthanasia were reported to us, even before the legislation came into effect.

There are two potential consequences of people's reluctance to present at clinics or go to hospital in a timely way because of these fears.

First, that in the event of say a relatively minor outbreak of influenza, if significant delays in presentation for treatment occur, there is a much higher possibility of potentially fatal complications such as pneumonia occurring. There is little need to remind the inquiry of the fact that Aboriginal people have far poorer health outcomes that the rest of the population.

Second, there is potential for the reputation of Northern Territory Health Services and many local clinics to be placed in jeopardy. Aboriginal health workers, in particular, informed us that the existence of the legislation, and the fear of it, made their positions difficult to maintain and one, unconfirmed, said that he would quit if the legislation was introduced. It was not just a simple issue of lack of willingness to be involved in the legislation, which they are not legally obliged to be in any case, but that they might receive 'blame' for deaths through the agency of euthanasia on communities or at hospitals, and be subject to payback.

A number of non-Aboriginal nursing staff and doctors have also expressed fears to us about their positions, their standing in communities, and their abilities to perform their work properly. Again, the impact of this on the health outcomes of Aboriginal people is difficult to gauge, but certainly makes a difficult task harder for the department and its employees.

It is worth noting, in this context, that private Aboriginal-owned clinics have demanded, and received, written undertakings from staff that they will not participate in euthanasia so as to reassure patients that these clinics are 'safe' to attend. Legal and other reasons preclude this occurring in government clinics, and an attempt to amend the ROTI legislation to exempt Aboriginal community clinics from participating in euthanasia failed to pass the NT Legislative Assembly.

None of the aforesaid should imply that Aboriginal people do not want to use and understand Western medical services. Along with traditional medicine, Western medicine is seen as valuable. The success of the Aboriginal Health Worker system and the establishment of Aboriginal community-controlled health centres is evidence of that. However, it does indicate potential problems down the track for the Territory Health Services and community clinics, as well as implications for Aboriginal health education.

Aboriginal versus non-Aboriginal Law

Some commentators, with greater or lesser knowledge, have suggested that traditional Aboriginal Law in the past either sanctioned or was silent on the issue of euthanasia, and that therefore the current ROTI legislation is acceptable to or does not offend Aboriginal Law.

However, one of the most widespread and persistent views expressed to us was that the ROTI legislation is 'against Aboriginal Law' and that, conversely, palliative care is the 'Aboriginal way'. In its most graphic form we were told '... it might be all right for that man in Darwin to kill his mother, but we don't do that here!'

From our experience it would seem, therefore, that whatever may or may not have been part of the Law in the past (and it is doubtful many people were asked about euthanasia until recently), opposition to euthanasia at present forms a part of the public ideology of Aboriginal Law.

There is widespread acceptance among Aboriginal people that there can be 'a time to die' and I have had direct and indirect experience of people refusing food and going off into the bush to die.

However, virtually all the people we spoke to expressed complete abhorrence at the notion of another person, such as a doctor, actively assisting in such a process, and this was consistently expressed in terms of it 'being against the Law'.

The 'Law', of course, is not codified in the way that non-Aboriginal Australia codifies or describes its laws but, in simple terms, Aboriginal people would regard the action of assisting suicide as a form of unsanctioned killing, and therefore illegal. By extension, the Aboriginal view as expressed to us is that the Government has broken Aboriginal Law by legislating to sanction such killings, and this is seen as a threat to Aboriginal people and Aboriginal Law.

There are, I believe, deeper problems at play here. Aboriginal people believe, as has been often noted, that they are subject to 'Two Laws' which often conflict: traditional Aboriginal Law and non-Aboriginal law. In the case of the latter, Aboriginal experience of this has largely centered on the criminal law and one of the fundamental precepts of the criminal law (and indeed traditional Aboriginal Law), is the obligation to obey the law or face sanctions.

The ROTI legislation appears to contradict this precept insofar as it can only be 'activated' through the voluntary choice of an individual — beyond which it is largely a law that regulates the actions of doctors and other participants in the process. Furthermore, the individual can — right up the end — voluntarily deactivate the process of the legislation. We encountered widespread disbelief that a law on such an important issue could be framed in such a fashion, and suspicion that the ROTI law might now or in the future be activated by individuals or the state on behalf of others.

As noted above, palliative care was universally supported by Aboriginal people as the way people have traditionally looked after their people under their Law.

Individualism versus collectivism

One of the great ironies of the ROTI legislation is that while its original drafting and subsequent amendments were designed to maximise and protect the role of the individual in the equation — it is this aspect of the legislation which most clearly transgresses and offends against Aboriginal ideas about civil society, which is collectivist in nature.

Indeed, many we spoke to were astounded that such a fundamental decision about life and death could, or should, be made without reference to the immediate family and extended relationships or others with ritual relationships to the person involved.

It is not that Aboriginal people suffer less in terminal illness, nor that they wish less relief from pain, but that ways of dealing with death are not, in general terms, alienated from the group. To make such a profound decision as volunteering to have one's life terminated via an external agent without participation by the extended group, and indeed with legislative protection and sanctions against being directly influenced by people other than the volunteering individual was seen as an anathema — and yet again, against the Law.

The majority view?

One of the most persuasive arguments in support of legislating in favour of voluntary euthanasia is that, in Western countries such as Australia, there has been substantial consistent long-term public support for such legislation, and that politicians should not stand in the way of such overwhelming public opinion. Figures of 70% support are often cited.

Apart from the populistically superficial nature of this argument, it is doubtful that the same could be said in the case of the Northern Territory. From our experience it would be my estimate that at least 90% of Aboriginal people in the Territory would be opposed to the legislation — quite probably higher. Given the fact that 22% of the Territory's population is Aboriginal, overall support for the euthanasia would be substantially less than that for the rest of Australia, possibly lower than 55%.

Conclusion

I have had the privilege of working with Aboriginal people for 25 years in four states, including 16 years in the Northern Territory. In that time I have been involved directly and indirectly in the funerals of perhaps 150 or more people known to me personally. In only two cases could it be realistically said that they have died of 'old age' in the normally accepted — to non-Aboriginal people — sense. Many more of my friends are currently facing premature death — largely as a consequence of their Aboriginality. It is a death toll that reflects the fact that Aboriginal people live on average 20 years less than non-Aboriginal people, and die prematurely of illnesses more characteristic of the Third World than suburban Canberra. It is a death toll that is reflected in the almost permanent state of mourning across regions of the Territory as people die — and the fact that mortuary rites dominate over other ceremonial life.

I personally support my having access to euthanasia — but not in the Northern Territory. It is arguably the right legislation — but certainly the wrong jurisdiction. My reasons for this are both simple and complex.

Whether the legislation is good or bad for us, as whitefellas within our own cosmology, is immaterial. I believe the very existence of the legislation poses an unacceptable risk to the health of Aboriginal Territorians who may delay or refuse to access health care because of fears they have of the legislation. Those fears are deeply embedded in Aboriginal world views. Put simply, it has the potential to lead to premature deaths amongst a group of people whose life expectancy is already unacceptably low.

Due to complex ways in which Aboriginal belief, social and cultural systems do not 'match' those of non-Aboriginal Australia, external reassurances about the 'voluntary' nature of the legislation will be unlikely to lessen the very genuine cultural misgivings and fears Aboriginal people have about the existence of the Act. While this law remains on the books in the Territory, it will continue to pose this threat to Aboriginal health.

This threat will continue for a very long time to come if Aboriginal world views about health and illness, life and death persist — and the evidence to date is that those world views have already persisted for a substantial period despite long-term contact with non-Aboriginal world views. This persistence of such world views is not amenable to 'education programs' in general — let alone the kind contemplated and carried out as part of the ROTI legislation education program — no matter how much support and good will is afforded by such a program. People, no matter what their cultural background, do not 'unlearn' their world view so easily.

I hope I make clear that I am not saying that Aboriginal people will be killed through any slippery slope mechanism whereby the weak may be vulnerable. Indeed the language/interpreter requirements of the Act make it all but impossible in the next half decade or so for the vast majority of Aboriginal people to access the Act, even in the unlikely event that they might want to. For Aboriginal people, a 'slippery slope' commenced prior to the existence of the Act.

But I do believe that there are very real risks to the health of Aboriginal people, by virtue of the existence of the legislation: it's what people believe about the legislation, not what may actually be contained within it. Frankly, I do not think Aboriginal people need another potential 'agency', let alone 'cause', of death.

I believe the 'debate' over euthanasia legislation has not come to grips with the reality of the jurisdiction in which it has been enacted — one in which such a high percentage of the population has such a radically different world view from the general population. The 'debate' has concerned itself entirely with either Western ethical/moral arguments, or arguments over the 'rights' of the Northern Territory to make legislation for itself without interference from the Commonwealth, that is, a 'states' rights' argument. Both lines of argument centre solely on a Western world view; both ignore Aboriginal world views.

Appendix II

101 VICTORIAN ONCOLOGISTS (CANCER SPECIALISTS) OPPOSE ASSISTED SUICIDE BILL

A letter from 101 Victorian oncologists, sent to all Victorian MPs, illustrates the strong opposition to the Andrews government's reckless proposal for assisted suicide and euthanasia.

19 September 2017

Dear Victorian Parliamentary Representative

We, the undersigned 101 Victorian Oncologists (cancer specialists), request that you vote AGAINST the proposed Victorian Assisted Dying Bill 2017.

As 80% of those who access physician assisted dying legally overseas have cancer, we feel our perspective on this issue should be heard.

We add our voices to the 100 palliative care specialists who have already corresponded with you requesting that you oppose the passage of this bill.

We collectively represent a significant proportion of the oncology workforce in the state of Victoria.

We do not believe that it is possible to draft assisted dying laws that have adequate safeguards to protect vulnerable populations, especially those with incurable cancer, progressive neurological illness, the aged and disabled. These groups of people experience high rates of depression and isolation. The risks that such legislation poses for the majority of these outweigh any benefits for the few in our opinion.

Physician assisted dying places people at risk of coercion that is both active and passive. As a consequence of assisted dying laws, society re-assesses the value of life; and the individual is taught to devalue their own life. Those with serious illness may perceive that they are a burden on society or their carers and come to feel that assisted dying is appropriate for them.

Assisted dying laws are easily challenged from a human rights and equality perspective. Indications over time will be extended beyond adults with terminal illness, to those with mental illness alone, dementia, disability, children and the healthy elderly who have "completed lives". In Oregon USA in June 2017 the senate debated a bill that would allow demented patients and others with "mental incompetence" to be starved to death. Oregon is not a lead that we wish to follow.

Physician assisted death is not, by definition, medical treatment. It is not palliative care. We as doctors and medical specialists do not want to intentionally end the lives of our patients, or provide them with the direct means to do so. Assisted suicide is in conflict with the basic ethical principles and integrity of medical practice and undermines trust in the medical profession. We strive to eliminate suffering but not the sufferers themselves.

Where cure of cancer is not possible, we seek optimal palliative care services to support and care for patients and their families at the end of life. Without easy access to quality palliative care, some may request physician assisted dying as they feel they have no other choice. This is especially so for people who live in rural, regional and remote areas and for people from culturally and linguistically diverse communities who have less access to palliative care services.

We are very disappointed that discussion of the Voluntary Assisted Dying Bill has dominated the agenda to improve end of life care in Victoria. We are dismayed that the multiple recommendations made by the Victorian Parliamentary Inquiry into End of Life Choices (June 2016) to strengthen palliative care have not been actioned. Until this is addressed, discussing physician assisted dying is premature.

In June 2017 the NSW government allocated an extra $100 million to fund palliative care services over 4 years, particularly to provide extra funds for community palliative care services and for rural and regional NSW. Need in these same areas has been identified by the Victorian End of Life Choices report. Palliative Care Victoria's figures demonstrate that an extra $65 million per year is required to meet deficits and adequately cover future cost projections in these areas. Such funding is essential if dying Victorians are to be adequately cared for in their homes with adequate supports for both them and their families.

We call for improved funding of palliative care services in Victoria, for the benefit of all Victorians, but especially those who live with incurable cancer and their families. This will go some way to ensuring that fear of suffering does not dictate a person's final hours, nor the memories their loved ones will carry throughout their own lives.

The United Kingdom parliament resoundingly rejected an Assisted Dying bill in 2015 as there is no "safe system" and we urge the Victorian parliament to do the same.

Yours sincerely,

THE UNDERSIGNED 101 VICTORIAN CANCER SPECIALISTS.
THE LISTED SIGNATORIES SUPPORT THIS STATEMENT AS INDIVIDUAL HEALTH PROFESSIONALS AND NOT AS REPRESENTATIVES OF ANY HOSPITAL OR OTHER ORGANISATION WITH WHICH THEY ARE ASSOCIATED.

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