SUBMISSION TO THE NORTHERN TERRITORY PARLIAMENTARY INQUIRY INTO VOLUNTARY ASSISTED DYING

I am an Old Age Psychiatrist. I received my Fellowship of the RANZCP in 2007 and my Advanced Training Certificate in Old Age Psychiatry in 2009. I also have a Masters of Geriatric Medicine and have experience working in palliative care settings. I am currently working in both the public and private sector in NSW. The views expressed here are my own and not those of my employer or other bodies.

My answers below are based on my clinical experience both before and after the introduction of VAD.

Do you support making VAD legal in the NT?

No, I do not support making VAD legal in the NT.

I have witnessed a negative change in clinical practice with the legalisation of VAD in NSW, as have many other clinicians. While VAD appears to be readily available in regional areas, palliative care services remain sparse in many areas, even in metropolitan Sydney. This means that patients do not have a real choice at the end of life. VAD should not be legalised until comprehensive medical, palliative care and psychiatric services are available throughout Australia.

In Australia we acknowledge that suicide is a major public health problem and therefore have a National Suicide Prevention Strategy and a National ATSI Suicide Prevention Strategy, with suicide rates remaining unacceptably high. Ironically, The National Suicide Prevention Strategy 2025-2035 aims to “continue to invest in and evaluate efforts to reduce the publication of material that promotes or encourages suicide in traditional and online media, and on online services and platforms”. Already we have seen Australian mainstream media advertising VAD since its legalisation, reinforcing the notion that some lives aren’t worth living. The problem of “contagion” with public reporting of suicidal behaviour has long been recognised. Suicide and VAD are identical behaviours so it is difficult to fathom why such advertising would be considered acceptable.

Suicidal thoughts are commonly seen in medically ill patients and may occur in the context of a mental disorder or demoralisation. Access to mental health care is poor in Australia, even in major cities, and mental disorders are often under diagnosed.

Social factors have a major part to play in impacting suicidal thinking. Addressing psychosocial factors in suicidal thinking is effective but, since the introduction of VAD, there has been the tendency of clinicians to fail to recognise that requests for VAD commonly represent suicidal thinking and should automatically trigger psychiatric assessment as a matter of patient safety.

There have been changes in the dynamics of the doctor patient relationship. Where previously patients were open to creative and wholistic medical care, to my observation they are foreclosing readily on VAD as a solution to their difficulties. These patients are highly vulnerable to suggestion and interpersonal interactions between patient and paid/ unpaid carers have changed since the introduction of VAD. Clinicians have seen patients change their attitudes after the intervention of pro VAD practitioners, when previously they were open to continuing with clinical care.

Doctors do bend rules when they think they are acting in a patient's best interests. This can be particularly dangerous when some doctors decide that VAD is in their patients' best interests. I have witnessed a discussion in which clinicians tried to work out how to facilitate the VAD decision, even when the patient is not eligible. In fact, the comment of one VAD practitioner was that "all you need is for two doctors to agree on a diagnosis, the (VAD) Board don't check the scans or anything". Junior clinicians seem to be particularly prone to an approach that encourages VAD rather than safe, wholistic care pathways.

Despite assurances that VAD is available to alleviate suffering, it is often the case that patients are choosing VAD, not for poorly controlled physical symptoms (eg nausea, pain), but due to existential distress. Existential distress can be ameliorated with psychosocial interventions. Patients have been quoted saying things such as "I might as well have VAD as I have no friends". The use of VAD in such situations is an indictment on the care our health system provides to the most vulnerable in society.

Prognostication is fraught in many patients and is not an exact science. Patients are highly impressionable when told by a doctor that they have a certain prognosis, regardless of whether this is realistic or not.

There are often clinically complex situations where it is literally impossible to rule out coercion by family members or others. This is especially the case where there is likely to be a large Estate to be distributed after the death of the patient or where the patient is perceived to be a "burden". The problem of coercion is a very common one in Old Age Psychiatry and can be difficult to detect. One often has a "gut instinct" which can be hard to prove. The stakes are particularly high when contemplating the irreversible decision of VAD.

Vulnerable patients are often worried that they are a burden on their family. Distressed family members often unwittingly convey the message that the patient is a burden. Once the idea of VAD is introduced into the mix, with the patient claiming their commitment to the notion family members may be quick to jump on board, claiming that all they want is what is best for the patient. When previously all efforts would be made to alleviate the distress of the patient and their carer, now there is little incentive to do so, with the "quick fix" of VAD available. Good clinical care has been undermined.

Capacity assessment is often complex, particularly in medically ill patients. Subtle cognitive impairment, whether due to subacute delirium or the prodrome of a neurodegenerative disorder, is often not recognised, even by doctors. Cognitive impairment, no matter how subtle, impacts decision making capacity. The complexity of this area means that differences of opinion with respect to capacity are common.

Experience indicates that VAD services and palliative care services become conflated in the minds of some patients and clinicians. Many doctors are ignorant of the difference between palliative care and VAD. Intentional poisoning of patients to end their lives (VAD) has never been part of the specialty of palliative care. This conflation can lead to fear among some patients of referral to palliative care services. This can be particularly pronounced in some cultural or religious groups. Institutional conscientious objection should be allowed to ensure “safe spaces” for members of the public who become frightened of the impact of VAD on their medical care.

Many clinicians do not agree that the deliberate poisoning of patients to end their lives is a medical intervention. Clinicians who are conscientious objectors feel intimidated to speak up about their unwillingness to participate or when they witness unsafe practice. This is especially the case for junior clinicians who are fearful of appearing as "troublemakers", compromising their future opportunities in the workplace. I am aware of at least one instance where a pro VAD practitioner has tried to undermine the rights of conscientious objectors. The sad fact is that conscientious objectors are the very practitioners who would be the “safest” to work in this area as they would apply the most cautious approach, but they do not wish to become agents of a State that places so little value on the lives of Its citizens.

It is ironic that there are trigger warnings at the beginning of the Consultation Guide to this Inquiry. This indicates that even those who are pro VAD understand the profound consequences of this issue for individuals and for society. Health professionals believe that a major reason VAD is being promoted is as a cost saving measure. It is very dispiriting that our political leaders and bureaucrats, who should be acting to protect and optimise the lives of their citizens via the provision of comprehensive healthcare, are instead promoting this destructive legislation.

2. What eligibility criteria should a person need to meet before they can access VAD?

I oppose the introduction of VAD completely. If VAD is requested, people should have referral to comprehensive palliative care services and have psychiatric and cognitive assessment. Psychosocial issues should be thoroughly addressed.

3. How could the NT make sure that an eligible person can access VAD in a safe and effective way, including people living in remote areas and Aboriginal and Torres Strait Islander People?

There is no way for persons to access VAD in a safe way as VAD is inherently unsafe.

Patients should self-administer the lethal substance, since the ethical principal underpinning VAD is one of patient autonomy. This may lessen the risk of psychological damage to health practitioners from administering lethal substances.

4. How could the NT monitor the process to ensure VAD is delivered safely and effectively?

A whistle blower system should be set up to ensure that abuses are reported and investigated. Existing systems in Australia currently rely on brave practitioners who are prepared to report abuses.

An independent body should monitor the reasons for patients choosing VAD and any adverse outcomes.

Death certificates should record VAD as the cause of death in the interests of transparency and allowing later research into all aspects of VAD.

Research into various factors related to VAD should be funded such as the reasons for undertaking VAD, the effect on families, the effect on health care workers. Rates of VAD should be closely monitored. Suicide rates in general should be monitored as this may well rise once VAD is legalised due to changes in social attitudes.