Submission to NT Parliamentary Inquiry into Voluntary Assisted Dying.

I commend the Legal and Constitutional Affairs Committee (LCAC) on its proposal to build on the information in the 2024 report of the Voluntary Assisted Dying Independent Expert Panel (Expert VAD Panel) rather than duplicate the previous comprehensive review.

The call for submissions and Dr Rahman's communication as LCAC Chair dated June 6, 2025, both summarise the terms of reference for the Inquiry. I am made somewhat uneasy by a comment in the latter "... noting the request for a response back by the end of September 2025, with specific initial focus on points 1) and 2) ...". The points referred to are preparation of a consultation paper, and extensive consultation with communities, particularly in remote areas.
The other three points, covering evaluation of VAD delivery models, identification of specific issues for the NT, and providing drafting instructions for model legislation are all directly relevant to practical outcomes. This suggests to me that they are considered to be of less importance at this time, and are liable to be further delayed and/or unable to be included in the LCAC report because of the short timeframe.

I do hope that commissioning the current Inquiry is not yet another delaying tactic by a government that does not intend to act on this issue whatever recommendations come from the LCAC, despite the terms of reference including production of drafting instructions if required.

Responses to the four key questions from page 5 of the consultation paper.

Many of my suggestions have been informed not only by my personal beliefs, but by having worked for over 30 years in medicine in urban and remote NT communities.

1. I fully support Voluntary Assisted Dying (VAD) availability in the NT and encourage Parliament to legislate this as soon as possible.
    a. It is unacceptable that we in the NT are denied an end-of-life option available to residents of every other jurisdiction in Australia.
    b. I understand the issues of acceptability within some communities, but it is equally unacceptable to deny the majority of residents who support such legislation, because of uncertainty within the minority.

c. It is important that NT legislation recognises that access to VAD is about individual autonomy and not about how valuable one's life appears to others. This is particularly important when a VAD application is received from a person who may have declined recommended treatment for a medical condition. No-one has the right to tell any other person that their situation is not as intolerable as they consider it to be.

d. Despite acknowledging the importance of family and community ties, the key and only final decision must be that of the person requesting VAD, given freely and without pressure or coercion.

e. Access to VAD is likely to reduce suicides in the elderly and terminally ill.

f. Access to VAD will be more equitable than currently, where a person needs to travel to Europe, or move interstate with transfer of all housing, banking etc arrangements (to indicate intention to reside there). These processes are very financially costly.

2. I believe that the following would be appropriate eligibility criteria:

a. Australian resident.

b. Ordinarily resident in the NT or having documented strong family or community ties to the NT. The NT is a very small jurisdiction with limited resources and extremely high demands on health services.

c. Person having attained the age of:

i. 18 years, OR

ii. 12 years if their condition is due to a severe, progressive, inherited and/or medical condition for which there is currently known to be no effective treatment and which is currently so advanced that it is causing or is about to cause unacceptable pain and/or disability, OR

iii. If a completed life is accepted as an indicator, a lower limit of at least 70 years.

d. People who are in any of the following situations when requesting VAD.:

i. Those with a progressive and/or terminal, medical condition who have reached the limits of ameliorative or palliative care they are prepared to accept. This should NOT require a forecast of time until death.

ii. People in severe, chronic pain or suffering that is unable to be relieved in a way that is acceptable to the person.

iii. People who do not have a progressive, terminal, medical condition or chronic unrelievable pain, but who find their situation intolerable. This may be due to disability, loss of personal autonomy, indignity, inability to influence care, only future will be unacceptable deterioration, etc.).

e. I would also like to see the future inclusion of the following:

i. People who have clearly stated in an advance personal plan that they do not wish to be in any of situations defined above, whether or not they would be suffering at the time from dementia, and who are now in that situation.

ii. People who have determined, and expressed over a long period of time (perhaps at least 6-12 months) that they have a 'completed life' and that they do not wish to enter into the state of decline in independence and of loss of personal dignity that they see as inevitable.

3. Accessing VAD.

a. I do not believe it helpful to prescribe a minimum time required before a VAD application can be approved. For some conditions it is well-documented that there is a usual course of sudden, rapid, severe deterioration. A person with such a condition may wish to access VAD in advance of catastrophic events.

b. I do however feel it appropriate in all instances to have at least two documented formal discussions with the applicant.

c. The normal approval process should involve two people, and include at least one registered Medical Practitioner ("doctor" in common parlance), who has been qualified for at least three (3) years. The second person involved in the approval process may be any of a registered Medical Practitioner, Nurse Practitioner (NP) or senior Aboriginal Health Practitioner (AHP), registered social worker, or other professional who has significant and ongoing responsibilities relating to the health and well-being of the applicant. Any of these may be nominated as the guiding person.

d. At least one of the practitioners should have an established relationship with the VAD applicant.

e. Practitioners and institutions that do not support VAD and will not be involved in any part of the process, should still be required to inform, and if necessary facilitate, the applicant's access to a practitioner or institution that will assist with and undertake the VAD process with the applicant.

f. It seems imperative that access to VAD discussion via visual teleconsultation is permitted, especially given the NT's remote areas. Ideally one consultation should be in person, but I don't think this should be an absolute.

g. In an urban setting access to VAD would be similar to that in place in other jurisdictions. There are sufficient health practitioners (as above) and pharmacists to enable the VAD process to occur in a safe, timely and effective manner.

h. In remote communities access may be somewhat more complicated, but this issue may not be as influential as it is often made out to be. The demand for VAD in such a setting is likely to be extremely small and could arguably be covered by the main service on a case by case basis. Many larger communities have a resident doctor, and often at least one senior NP and/or AHP also; many smaller communities have medical visits fortnightly. Many residents of even small outstations come to 'town' (= nearest large community, if not one of the urban centres) fortnightly for shopping or other reasons. During the Wet season, access is more difficult, but not impossible.

i. The location of VAD substance administration should accord with the wishes of the person accessing it, although practical constraints may require these to be modified.

j. Administration of the substance should be either intravenous or oral, according to the person's choice and/or physical capabilities, and should be under the guidance of a health professional (medical/nursing/Aboriginal Health practitioner). I believe its administration should be witnessed by at least one additional person present at the time of administration. The witness should be relatively independent, ie should not be in the close family or friendship circle of the person accessing VAD or of the administering practitioner. Other people may also be present if the person wishes, but they should not be directly involved in the administration of the substance.

k. The VAD substance should ideally not be dispensed until its usage is thought to be imminent. Any unused substance should be required to be returned to the issuing pharmacy in a timely manner. In remote areas a suitable secure intermediate storage location may need to be nominated.

l. It will be vital to have an effective support network in place for people wishing to access VAD and their families (and communities if that is appropriate). This should be accessible at all stages of progress towards and then following the VAD event.

4. Monitoring.

   Medical practice already mandates effective monitoring and reporting of many events. These include, just for example: perinatal deaths, incidence of a large number of infectious diseases, administration of vaccines, usage of controlled drugs, to name but a few.

   a. It is preferable to have a death certificate record the immediate cause of death as the condition/s that have prompted the person to access VAD, and not the VAD itself. Death certificates currently do not have a field where VAD may reasonably be entered.

   b. I propose that a VAD notification process, similar to those already used for notification of other medical events, could be developed relatively easily. Such a form, like for example infectious disease notification, would contain sufficient details to satisfactorily identify a person (eg Medicare number - which is usefully almost universally available for residents of remote communities) and should capture information desired for monitoring such as date and place of VAD administration, people present etc.. It would be compulsory and required to be completed by any or all of several persons, in order to ensure the occurrence is captured. This is similar to compulsory notification of some diseases, where both the laboratory and the treating practitioner are separately and specifically required to notify the condition. Such persons could include the administering practitioner (with a signature from the witness), but also the pharmacist issuing the substance and the guiding practitioner. Details recorded would permit linkage with a death certificate.

   c. A pharmacist notification could be cancelled if the substance is returned entirely unused.

   d. I suggest that a review of progress towards bringing the legislation into operation be conducted every six (6) months, to ensure momentum continues.

   e. Initial review of VAD requests and outcomes could occur at three (3) years after the legislation comes into operation and at the same interval for at least the first ten (10) years.

END OF SUBMISSION