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13 August 2025

Northern Territory Legislative Assembly Committee on Voluntary Assisted Dying  
Via e-mail  
[LA.VAD@nt.gov.au](mailto:LA.VAD@nt.gov.au)

Dear Sirs and Madams,

**Inquiry on Voluntary Assisted Dying (VAD)**

[REDACTED]  
[REDACTED] I am writing in my personal capacity, and my views expressed here do not represent any organisations that I am currently or was previously associated with.

I understand that submissions are being published on your website, and I am willing for my submission to be published, however, I would like all my identifying details to be removed.

I would like to bring your attention to some important issues regarding the discussion regarding legalising VAD in the NT. My views are shaped firstly by my professional experience [REDACTED]  
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[REDACTED]

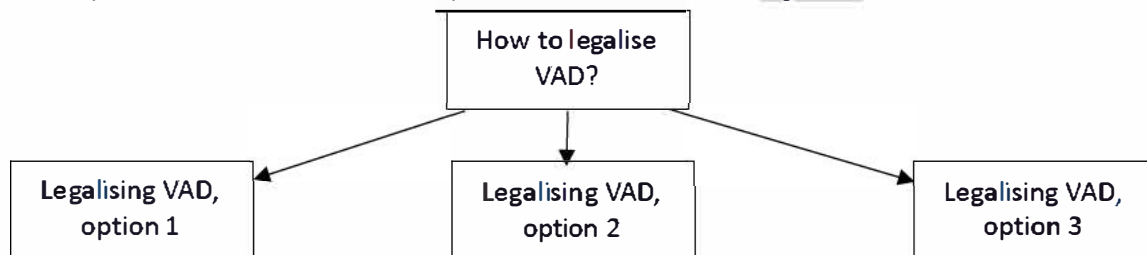
where I take a 'big picture view' of the health of a population.

**1. Ask and answer the appropriate questions**

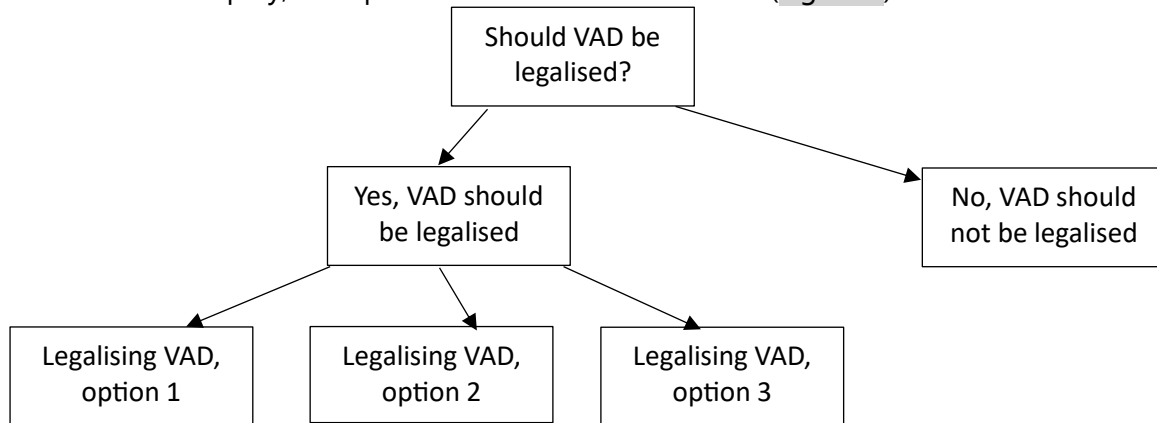
I am concerned that since the beginning of the public consultation on VAD in 2023, the focus is on HOW it should be legalised, but almost no attention was given to the WHY.

**Not legalising VAD is a valid option, which must be sincerely considered.** Simply giving Territorians the opportunity to say 'no' is not enough; the Committee and Legislative Assembly must also give sincere consideration regarding what to do if VAD is not legalised.

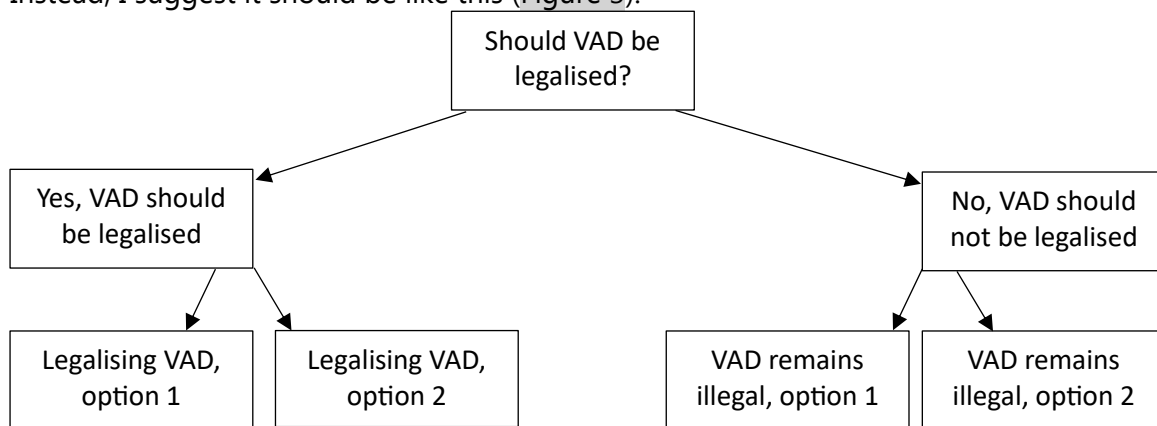
In the previous consultation, the option tree was like this (Figure 1):



In the current inquiry, the option tree seems to be like this (Figure 2):



Instead, I suggest it should be like this (Figure 3):



I am concerned that in the 2023-4 public consultations on VAD, the framework that was proposed was according to Figure 1, and for the current inquiry the framework is according to Figure 2.

In my view, Figure 1 and Figure 2 are inadequate and do not give sufficient options. If the options appear to be either “do nothing and let people die without dignity” or “legalise VAD to die with dignity” then naturally the option of VAD would be favoured. Instead, Territorians deserve to be given a real choice of options. Therefore, I suggest that Figure 3 is the appropriate option tree to be considered.

In considering Figure 3, I am confident that there are many people who have put forward strong and valid arguments on the left side of the figure, namely “yes, VAD should be legalised”, and there are many valid options for how it could be legalised, which have been quite thoroughly covered in the 2024 NT VAD report, hence I do not have anything to add to those options. Instead, the purpose of my writing is to focus on the right side of the figure, on the ‘no’ position.

**Giving Territorians only the ‘yes’ option(s) to consider is unfair.** It is only fair that the options for not legalising VAD are also considered seriously by both the community and legislators. Below, I give some suggestions on options that could be seriously considered

and developed in order to give more dignity to people who are dying in the NT, while not legalising VAD.

## **2. Have the discussion about VAD firmly in the context of Aboriginal health and health disparities**

Whenever we talk about health and health care in the NT, it is almost always in the context of Aboriginal health, and specifically, in the context that **Aboriginal Territorians are younger, sicker, and use more health care services.**

The 2024 VAD report acknowledges that Aboriginal health is an issue when considering VAD, but instead of considering it as one of the many issues to be acknowledged, I believe that instead, **Aboriginal health should be at the centre of discussions.**

The 2024 NT VAD report provides a reasonable overview of the burden of disease in the NT compared to other jurisdictions (pp 99-100), and I agree that “non-cancer diagnoses, outside of neurological disorders...[is a] unique feature of NT’s population [and] requires careful consideration” in the context of VAD. My perspective is that it does not simply require “careful consideration” but I believe it provides sufficient reason to seriously reconsider the need for VAD in the first place.

‘Closing the gap’ in life expectancy is arguably one of the most common themes when discussing health and health care in the NT. The gap in life expectancy between Aboriginal and non-Aboriginal Territorians is still around 15 years for both men and women, which, granted, is slightly better than before.<sup>1</sup> However, when taking into account healthy life expectancy, more recent analysis shows that the gap is more than 26 years for males and 33 years for females – that is, Indigenous males in the NT can be expected to live 26 years less of healthy life than non-Indigenous males in the NT, and Indigenous females in the NT can be expected to live 33 years less of healthy life than non-Indigenous females in the NT.<sup>2</sup>

The gap in life expectancy between Indigenous and non-Indigenous Territorians is due to preventable diseases and injuries.

Despite the younger age of Territorians compared to Australians in other jurisdictions, Territorians, especially Aboriginal Territorians, have a disproportionate rate of these preventable diseases and injuries. For example:

- The incidence of kidney failure is over 10 times more in the NT than in Victoria or NSW.<sup>3</sup>
- Approximately 25% of Aboriginal Territorians have cardiovascular disease, as compared to 15% of non-Indigenous Australians.<sup>4</sup>

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<sup>1</sup> <https://www.mja.com.au/journal/2022/217/1/improved-life-expectancy-indigenous-and-non-indigenous-people-northern-territory>

<sup>2</sup> <https://pophealthmetrics.biomedcentral.com/articles/10.1186/s12963-024-00335-z>

<sup>3</sup> <https://www.indigenoushpf.gov.au/measures/1-10-kidney-disease>

<sup>4</sup> <https://www.indigenoushpf.gov.au/measures/1-05-cardiovascular-disease>

- Suicide rates in the NT (14-30 per 100,000 population) are consistently higher than the rest of Australia (10-15 per 100,000 population).<sup>5</sup>

In view of the NT having finite resources, it would be logical that those resources should be prioritised to ensure that Territorians should be prevented from acquiring those life-limiting diseases in the first place, and when they are diagnosed with such diseases, they are given every opportunity to live long and healthy lives despite the diseases.

Conversely, it seems illogical that resources should be diverted to VAD when **the task of 'closing the gap' is far from complete.**

Therefore, describing VAD as an "equity" issue is illogical. When so much of the discussion and effort is to facilitate longer and healthier lives to the most disadvantaged Territorians, facilitating access to deliberately ending lives is illogical. I (and probably many others) think that **using the word "equity" is inappropriate in the context of VAD.** I believe that by legalising VAD in the NT, it brings further inequity in an already highly inequitable situation. Instead, to truly work towards more health equity, investing in more health and social services is most logical (as I discuss below).

I agree that with the current Consultation Paper (pp 16-17) that many Aboriginal Territorians have had difficult past experiences with the health care services. In my own experience working as a health professional in the NT since 2005, ensuring that my patients trust me and the health care system is my constant consideration.

I am very concerned that the concept of **allowing health professionals to kill patients in the name of VAD would risk reversing the hard-earned gains in Aboriginal health in recent decades.** Throughout my career in the NT, I have seen increasing investments in Aboriginal health, and despite the many challenges that remain, I believe that Aboriginal Territorians now generally have less fear in engaging with health services than when I first arrived in the NT in 2005. Back in 2005, part of my orientation included being told that Aboriginal patients were afraid of coming to hospital because that is where they would die. Now, people going to Alice Springs Hospital only to die is less common, and I have seen that trust in health services has been gradually improving over the years.

As a doctor, I have had many experiences over the years where, despite my best efforts, communication with my Aboriginal patients is not the clearest. Exceedingly few (if any) doctors in the NT and nurses speak Aboriginal languages fluently and the supply of Aboriginal interpreters is likely never to meet demand. It is no secret that mis-interpretation of the doctors' messages and the patients' intent occurs regularly, and probably far more frequently than recognised. I have had distressed Aboriginal patients asking me and my colleagues to kill them because they are fed up with their disease and their treatments. If VAD were a legal option, then the misinterpretation of a request for death by a frustrated and unhappy patient with advanced illness, could lead to health professionals facilitating VAD where death may not have been the real intention of the patient. While resources could

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<sup>5</sup> <https://www.aihw.gov.au/suicide-self-harm-monitoring/data/deaths-by-suicide-in-australia/suicide-deaths-by-state-territories>

be poured into investigating the real intention, those resources are better used to provide the actual care of the patient.

In short, I (and probably many others) am very concerned that legalising VAD in the NT is likely to cause set-backs in Aboriginal health, and **bring more unnecessary complexity in an already very complex and very challenging health environment**. I and countless other health professionals and non-health professionals have worked very hard over decades so that Aboriginal Territorians can have longer and healthier lives, and I would be distressed to see this trend reversed. Safeguards could be put into place, but safeguards are unlikely to be fully effective and are likely to be very resource-intensive. Conversely, **the resources that could be used to make VAD 'safer' would be better used to actually continue providing high-quality and life-saving care**.

### **3. Ensure that all diversity of voices are heard**

The 2024 NT VAD report mentions that Aboriginal Territorians are disproportional users of medical services (pp 99-100), which matches with my knowledge and experience. Given that fact, I argue that **Aboriginal Territorians should be given a disproportionately larger voice in the current discussions**.

The VAD report states that there were many ways in which Territorians' views were heard during the consultation (p 23). It would, therefore, be very helpful and reassuring if the authors of the report would provide data on the ethnicities of the people who submitted their views in all the various consultation methods. Providing the Indigenous status in health data is the norm in Australia,<sup>6</sup> and this is partly to ensure equity, that is, Indigenous voices are fairly represented and their interests are fairly addressed in regards to VAD, which is an issue of health care access, usage, and acceptability.

Considering that Aboriginal Territorians consist of around 70% of hospital patients, then it would be reasonable to have around 70% of consultation respondents identifying as Aboriginal. Moreover, it would be important to ensure that **the opinions of the most medically and socially vulnerable are elicited and seriously considered**, as they are potentially most affected by any VAD legislation.

However, from my experience of interacting with Aboriginal friends and patients, I imagine that some of the most frequent users of health care services in the NT are less likely to participate in online surveys, attend consultation meetings in regional centres, and submit written opinions via e-mail. Also, as the VAD report wisely notes: "the risks created by **power and knowledge imbalances** that exist for both Aboriginal and Torres Strait Islander patients using health care services and practitioners" (p 50, emphasis added). Even starting with the consultation process, these power and knowledge imbalances should be re-balanced. Therefore, in view of health equity, and in the spirit of decolonisation, that **data on the ethnicity of respondents in the 2024 consultation and also in this current inquiry ought**

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<sup>6</sup> <https://www.aihw.gov.au/reports/indigenous-australians/national-guidelines-collecting-health-data-sets/summary>

**to be provided by the Committee**, and no consultation should be considered complete until opinions are heard equitably.

Also, the VAD report recognises that there are large numbers of migrant Territorians (p 7), and indeed, tens of thousands of Territorians were born overseas.<sup>7</sup> Knowledge and power imbalances, especially in the context of health care, are likely to be relevant for some migrants.<sup>8</sup> Considering that many migrant Territorians are from non-English speaking homes, their views must also be adequately represented. There are many reasons why migrants, especially migrants from non-English speaking backgrounds, may be less likely to share their views on VAD. Therefore, it is important in the 2024 and current inquiries demonstrate that **culturally and linguistically diverse Territorians** have had the opportunity to honestly answer the question “should VAD be legalised in the NT?”

#### **4. Do more to improve existing health and social services for the ill, elderly, frail, and dying**

Given that there are finite resources in the NT, it seems right that those resources are allocated to benefit the largest number of people, and to facilitate longer and healthier lives, with more dignity.

The 2024 NT VAD report acknowledges that “caring for and managing older Aboriginal individuals over the long term is becoming progressively challenging” (pp 99-100), which I agree with. Also, the report notes (p 22) that home care and residential aged is limited for people who live outside Darwin and Alice Springs. These are precisely reasons for increasing resource allocation to **provide more and better care to the elderly and frail**, rather than giving the option of assisted suicide to reduce the need for care.

An analysis of data from Canada (from one part of Ontario province) showed that people of lower socio-economic status disproportionately requested VAD.<sup>9</sup> There are also news reports in Canada that some people requested VAD because of lack of social supports.<sup>10,11</sup> Considering the high prevalence of socio-economic disadvantage in the NT,<sup>12</sup> and the challenges of delivering medical and social services in the NT, I am concerned that similar scenarios could happen here, where socio-economic disadvantage becomes a motivator for requesting VAD. Therefore, I suggest the solution is to **increase medical and social supports**, and not to facilitate death by VAD.

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<sup>7</sup> <https://www.abs.gov.au/statistics/people/population/australias-population-country-birth/latest-release>

<sup>8</sup> <https://bmcpublihealth.biomedcentral.com/articles/10.1186/s12889-022-13256-z>

<sup>9</sup> <https://pmc.ncbi.nlm.nih.gov/articles/PMC9344489/>

<sup>10</sup> <https://ottawa.citynews.ca/2022/10/14/ontario-man-applying-for-medically-assisted-death-as-alternative-to-being-homeless-5953116/>

<sup>11</sup> [https://www.thestar.com/interactives/after-a-lifetime-of-trauma-michael-fraser-was-housebound-by-incurable-disease-and-poverty-he/article\\_66a96dac-b478-11ed-b48d-c34ad70c0f7e.html](https://www.thestar.com/interactives/after-a-lifetime-of-trauma-michael-fraser-was-housebound-by-incurable-disease-and-poverty-he/article_66a96dac-b478-11ed-b48d-c34ad70c0f7e.html)

<sup>12</sup> <https://www.abs.gov.au/statistics/people/people-and-communities/socio-economic-indexes-areas-seifa-australia/latest-release>

Considering that the population of the NT is small and young compared to that of other states, then it would not be too difficult to aim to have the care of older and frail Territorians as being the best in the country. Instead of putting resources towards VAD, how about allocating more funding to those who are finding their later years of life difficult, and instead give them more dignity, more choices, and more control? A little **innovation and creativity** could be used to address this issue.

I suggest increasing investment in palliative care services; how about to the extent that the NT has **state-of-the-art palliative care**? That would benefit all Territorians who end up dying in the NT, including those with the most unpleasant symptoms that motivate requests for VAD.

In addition to increasing funding to clinical services at the end of life, a little innovation and creativity could be used to invest in **non-clinical services to improve the quality of life and dignity of those who are dying**. For example, because many Territorians' suffering increases due to the loneliness and isolation from being far away from family and friends interstate, or even just on the other side of the Territory, how about giving grants to Territorians who are terminally ill, in their last months of life, so family and friends could visit from interstate? Suffering in terminal illness can be partially relieved by psycho-social measures, not just clinical measures,<sup>13</sup> and these measures in the NT deserve more investment of resources.

The 2024 NT VAD report also notes (p 53) that there is "a noticeable level of misinformation or lack of knowledge about the nature and scope of palliative care services offered in the Territory...the Panel concludes that there is **an obvious and immediate need for promotion and public education about the nature and scope of palliative care options**" (emphasis added). I think this is a very important finding. This leads me to recommend that, rather than legalising VAD as one of the end-of-life options, the priority should be to **clearly educate the public about all aspects of quality palliative care**, how it can help people with incurable diseases, and so on, before introducing VAD.

Data show that **countries and states where VAD is legal end up spending less on palliative care than jurisdictions that don't have VAD**. For example:<sup>14</sup>

- Between 2012 and 2019, the four European countries with assisted suicide (Belgium, the Netherlands, Luxembourg, Switzerland) increased palliative care provision by 7.9%, while the twenty non-assisted suicide countries in Western Europe increased provision by 25%.
- Between 2015 and 2019, palliative care teams in hospitals increased by 3.2% in US states with assisted suicide while non-assisted suicide states saw an increase of 9.4%
- In 2022, New South Wales committed to spend an extra \$743 million on palliative care over five years when VAD was legalised. However, in 2023 this decision was revisited and the palliative care budget was cut by \$249 million in one year, resulting in cuts to

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<sup>13</sup> <https://www.nursingtimes.net/end-of-life-and-palliative-care/psychosocial-interventions-in-palliative-and-end-of-life-care-18-11-2024/>

<sup>14</sup> <https://bioethics.org.uk/media/t1bf0icr/evidence-of-harm-assessing-the-impact-of-assisted-dying-assisted-suicide-on-palliative-care-prof-david-albert-jones.pdf>

palliative care staff and services. At the same time, New South Wales allocated \$97.4 million in new funding over 4 years to rolling out VAD.

I (and probably many others) would be very upset if in the legalising of VAD, budgetary allocations in the NT would follow the trend of other jurisdictions and be diverted from palliative care and other essential health services to VAD. **Health and social care budgets must be prioritised for providing essential health and social services, including palliative care, and not for VAD.**

The 2024 NT VAD report notes (pp 30-31) that a “care navigator service” should be created to support patients considering VAD. I wish that all my patients with complex health issues (chronic disease or otherwise) could each be assigned a **“care navigator” to manage the complexities of managing their non-terminal conditions!** I have seen many of my patients unable to manage the complexities of getting enough comprehensible information and going between many different service providers, hence many of them lose hope in regaining their health. I therefore suggest that “care navigators” should be created in the NT for all complex health conditions. Investments should be made to help people live, not just to help people die.

In addition to creating “care navigators” for complex health issues, I believe that any extra resources that might be allocated for VAD are better used to **fund more essential health services** that benefit more Territorians. As a remote general practitioner in Central Australia:

- I usually cannot get patients with poorly-controlled diabetes to see one of the very few diabetes nurse educators, knowing that if their diabetes remains uncontrolled then they will die younger due to the complications of kidney disease and heart disease.
- I have had patients in significant mental distress, and trying to get them to see a psychologist has been almost impossible because there are exceedingly few.
- I know that obesity leads to premature death, and national guidelines tell me of all the specialists that I need to refer my patients with obesity-related conditions to,<sup>15</sup> but I can't refer them to a dietitian nor an exercise physiologist because they don't exist, but yet unhealthy foods are plentiful.
- My highly-skilled remote area nurse colleagues work very long hours under difficult conditions just to provide basic health care, and nursing workforce shortages are still unresolved.
- I have seen many of the remotest and most marginalised patients who do not have continuity of care from a GP, because a different locum doctor comes every month, each with different skills and management approaches for the many chronic diseases. Undoubtedly, some remote patients' health is compromised because they don't have one GP following them over months and years, especially if they have low health literacy, as many of the remote patients do.

Furthermore, instead of spending resources on VAD which would directly benefit few people and potentially disadvantage many, or investing in large amounts to make VAD safer for those who might be harmed by VAD, it would be more prudent to spend those **resources on addressing the multiple health challenges that are faced by large proportions of**

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<sup>15</sup> <https://www.diabetessociety.com.au/guideline/obesity/>

**Territorians.** All Territorians deserve to have better health services so they can live healthier and more dignified lives, despite the challenges of remoteness.

In conclusion, in a place such as the NT where there are innumerable health care needs that have yet to be funded, palliative care access is limited, and socio-economic disadvantage is obvious, then it is illogical to allocate funds to legalise VAD.

## **5. Legalising VAD does not decrease unassisted suicides and may increase unassisted suicide rates in vulnerable populations.**

One major argument that has been given to urge the legalisation of VAD is that it would prevent unassisted suicides, but there is little data to support that. Conversely, several analyses of suicide data in different countries, including Australia, shows that **suicide rates, especially of women and the elderly, increase after VAD is legalised.**

- One analysis of suicide rates in the elderly in Victoria shows that suicide in people over 65 years of age increased after VAD was legalised in 2017, despite advocates saying that legalisation of VAD would prevent one suicide per week in the elderly (this research was published in the Journal of Ethics and Mental Health, 2023).<sup>16</sup>
- An analysis of thousands of people using VAD over decades in the United States, Belgium, Switzerland, and the Netherlands found that the data “do not support the claims made that the introduction of euthanasia and assisted suicide results in reduced rates of non-assisted suicide” and “studies based in Switzerland and Oregon suggest that older women might be disproportionately vulnerable to euthanasia and assisted suicide where this is legislated for” (this research was published in the British Journal of Psychiatry Open in 2022).<sup>17</sup>
- Researchers who analysed VAD data from the United States stated “we find evidence that legalisation of assisted suicide is associated with a significant increase in total suicides. The increase is observed most strongly for the over-64s and for women. There is weaker evidence that assisted suicide is also associated with some increase in unassisted (unregulated) suicides, most particularly in the 35–64 age group and for women. In sum, we do not find any support either for the suggestion that legalising assisted suicide might reduce total suicides or that it will reduce unassisted suicides” (this research was published in the European Economic Review, 2022).<sup>18</sup>
- An analysis of data in the United States found that “legalizing physician assisted suicide was associated with a 6.3% increase in suicides...and no decrease in non-physician assisted suicide” (this research was published in the Southern Medical Journal, 2015).<sup>19</sup>

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<sup>16</sup> [https://irp.cdn-website.com/c0d44f22/files/uploaded/Did\\_the\\_Voluntary\\_Assisted\\_Dying\\_Act\\_2017.pdf](https://irp.cdn-website.com/c0d44f22/files/uploaded/Did_the_Voluntary_Assisted_Dying_Act_2017.pdf)

<sup>17</sup> <https://www.cambridge.org/core/journals/bjpsych-open/article/investigating-the-relationship-between-euthanasia-and-or-assisted-suicide-and-rates-of-nonassisted-suicide-systematic-review/223FDD723EB5CAE84D2EF02C65A9F446>

<sup>18</sup> <https://www.sciencedirect.com/science/article/pii/S0014292122000551>

<sup>19</sup> [https://www.researchgate.net/publication/282609275\\_How\\_Does\\_Legalization\\_of\\_Physician-Assisted\\_Suicide\\_Affect\\_Rates\\_of\\_Suicide](https://www.researchgate.net/publication/282609275_How_Does_Legalization_of_Physician-Assisted_Suicide_Affect_Rates_of_Suicide)

Given this research on suicide and VAD data from several countries, including Australia, it is incorrect to claim that legalising VAD would decrease unassisted suicides. Especially in the context of the NT, where suicide rates are consistently higher than the rest of Australia,<sup>20</sup> legalising VAD seems quite illogical.

## **6. Conclusions – consider the health of all Territorians, especially the most medically and socially disadvantaged Aboriginal Territorians**

Finally, I acknowledge that legalising euthanasia is about giving people autonomy about when and where they would like to die. But if, by granting autonomy to a few, many others end up at risk, that is not a fair decision. In the same way, while many people want to be able to drive without speed limits on the Stuart Highway, they can no longer do so because of the law of the 130 km/h speed limit that attempts to protect all road users. I (and probably many others) was very relieved in 2016 when NT Legislators took the bold decision, based on a public health approach, to reinstate speed limits on the Stuart Highway despite strong lobbying for open speed limits. Likewise, I urge this Committee and legislators to be equally bold now, to consider the 'big picture' of health of all Territorians and not simply consider those who are strongly lobbying for VAD. Laws never make everyone happy, but **laws are surely made to protect the vulnerable**, and in legalising VAD, the most medically and socially vulnerable Territorians are likely to be put in an even more vulnerable position.

In conclusion, I reiterate the following:

- Legalising VAD in the NT may benefit a small number of people but risks harming a larger number of the most vulnerable.
- Having the discussion about VAD in the NT should be made with Aboriginal health firmly in the centre of the discussion, and the views of the most medically and socially vulnerable Aboriginal patients must be sought.
- Spending large amounts of money on trying (perhaps futilely) to make VAD "safe" is better spent on the many health and social needs where many Territorians, including Territorians with terminal illnesses, can benefit.

Surely NT legislators do not want to be judged to be on the wrong side of history by pushing through legalisation of VAD as one of the many policy or legal decisions that, in the future, might be considered harmful to Indigenous Australians.

I greatly appreciate your serious consideration on my views on VAD in the NT. If you require clarification, please feel free to contact me on [REDACTED]

Yours sincerely,

[REDACTED]

[REDACTED]

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<sup>20</sup> <https://www.aihw.gov.au/suicide-self-harm-monitoring/data/deaths-by-suicide-in-australia/suicide-deaths-by-state-territories>