To the Parliamentary Legal and Constitutional Affairs Committee, Voluntary Assisted Dying Northern Territory Government

14 August 2025, New Zealand

Dear Committee Members

Thank you for the opportunity to have input into your deliberations and to make comment from our observations of voluntary assisted dying (VAD) practice in Aotearoa New Zealand (NZ).

We are the End-of-Life Choice Society NZ (the Society). The Society is the only advocacy group in NZ that fights for the right-to-die with dignity which we consider to be the last human right to receive attention. The Society was incorporated in 1979 as the Voluntary Euthanasia Society NZ and changed its name to the End-of-Life Choice Society NZ in 2017. It actively promotes information about the End of Life Choice Act 2019 to its members and to the general public via its website at https://eolc.org.nz/ , its Facebook page https://www.facebook.com/EndofLifeChoice/ and its Twitter account.

VAD has been available in NZ since 7 November 2021. Our Ministry of Health (MoH) is the regulatory body for VAD practice. A second arm of the Health Department, Health New Zealand/Te Whatu Ora, is responsible for its implementation. Te Whatu Ora makes data-based information about VAD available to the public at quarterly and yearly intervals (see samples later in this submission). To date the VAD service is flowing smoothly.

The Society enjoys a cordial relationship with the MoH's Assisted Dying Service.

From our experience of VAD practice, we offer recommendations for your consideration. In some instances, we will be urging you to follow a format similar to that of NZ as this has led to safe, accessible practice. In others we would be urging you to avoid repeating our errors as they have led to unnecessary additional suffering and/or complexity for no additional benefit.

Do we support making VAD legal in the Northern Territory?

Unequivocally, yes.

Eligibility criteria for VAD?

- The Society fully endorses the standard eligibility criteria of willingness and mental competence.

- The primary consideration should be unbearable suffering, caused by a medical condition, that cannot be relieved in any manner tolerable to the person. Degree of suffering should be determined by the person and should not be confined to physical pain only, but include existential, emotional and psychological suffering. Anticipatory suffering should be an acceptable reason for desiring to hasten death. For example, the anticipatory horror of the final stages of dementia should be a justifiable reason for early access to VAD.

- The secondary consideration should be the degree of "advanced state of irreversible decline in physical capability". This is (verbatim) one of the eligibility criteria that must be met in the Act. The

Society has not found it to be a deterrent to VAD access for persons whose need is recognisably valid, but rather a descriptive indicator that is helpful to physicians and comforting to legislators.

- The Society very strongly recommends that no estimated remaining time until death be a requirement to access VAD.

- In situations where mental competence may be lost in future (e.g. dementia, brain damage through accident), it should be possible to access VAD by advance directive.

- In situations where mental competence may be lost during the process of application for VAD (e.g. brain tumour, already so close to death as to lapse into semi-consciousness or needing to reject pain relief medication in order to maintain mental clarity), it should be possible to access VAD by "waiver of final consent" as soon as the applicant is found eligible.

Access to VAD in the Northern Territory context?

We do not pretend to be knowledgeable about the Northern Territory context, but the following have been/would be helpful elements to person, family and practitioners while simultaneously acting as safeguards:

- Allow practitioners to raise the topic of VAD with relevant patients provided it is presented as only one option for end-of-life care amongst all the other options. This forestalls unnecessary suffering due to lack of knowledge about VAD, it enables people to make properly informed decisions and enables practitioners to comply with their professional duty to fully inform in all circumstances and then help their patients make decisions that are best for that person.

- Allow nurse practitioners as well as doctors to be involved in all aspects of VAD. Our understanding from nurse practitioner association NPNZ is that nurse practitioners are well capable of these tasks. The Expert Advisory Panel may find the same to be true of experienced nurses. NPs and nurses are more readily available to the person and family than the doctor is, especially in care home facilities, and are especially skilful in understanding family dynamics which is a safeguard against coercion one way or the other.

- NZ has found it sufficient to require that the first doctor hold a practising certificate recognised in our jurisdiction and that the second doctor hold a recognised practising certificate and have a minimum of five (5) continuous years of practice. We have not found it necessary to require assessment by specialists within that person's disease category.

- NZ has found it sufficient for the person to sign the formal request in the presence of their first doctor only; we have not found witnesses necessary. If the person is unable to sign, then they can allocate that duty to another party who should sign on their behalf but in the presence of the

doctor and simultaneously of the person. This saves an unnecessary administrative burden and takes the onus off the person to provide their own dependent and independent witnesses. There have been no breaches of our Act to date.

- The Society strongly recommends the creation in the legislation of a statutory body similar to our SCENZ (Support and Consultation for End of Life NZ). This is where documentation is centralised for purposes of progressing an application from step-to-step, for checking that all steps have been completed so that there are no breaches of the legislation, for review and reporting.

- We recommend requiring regular reporting to be made publicly available online (e.g. quarterly as here.) This demystifies the service and is a transparent counter to unhelpful fearmongering.

- We recommend creating the role of care navigator as per the other Australian states and NZ. They are enormously appreciated by applicants, families and practitioners. They promote continuity within each case and are very helpful with paperwork, saving practitioners a great deal of time.

- Please consider allowing multiple methods of administration of the medication and allowing eligible persons to select their preference as in NZ. Our legislation provides for four options: two for self-administration and two for practitioner administration. Most people prefer practitioner-administration which is often also preferred by practitioners themselves as being the more certain method. Even when the person requests self-administration, the practitioner carries a "back-up pack" of medication suitable for practitioner administration. NZ's statistics will prove to you that this does not encourage overuse of VAD. Te Whatu Ora's first year report shows that assisted deaths were 0.7% of total deaths (257 assisted deaths out of approx. 37,500 total deaths in a population of 5.2 million). This tiny percentage is accounted for by the recency of the service, the greater number of deaths than usual due to it being a Covid year (2021 – 2022) and our overly restrictive eligibility criteria; it is clearly not accounted for by having the option of physician-administered VAD.

- The Act requires the practitioner to be present at the time of administration of the medication, including self-administration, and to be available to the person until death. This in turn requires nominating a date which is at the discretion of the person. The Act allows the person to postpone their nominated date for up to 6 months, after which time they become ineligible. They can, however, re-apply. We have not found this to be a deterrent to practice.

- We recommend that the Northern Territory legislation require the practitioner at several points to remind the person that they can change their mind right up to the last minute, as per our NZ legislation. This is a safeguard against family influence or sense of obligation to carry through.

Monitoring the process

We recommend reflecting the Australian Capital Territory model in Northern Territory legislation.

Other recommendations:

- The Society recommends that, while respecting the right to conscientious objection, all health facilities and care facilities be required to respond effectively to a request for information about VAD and/or to a request for VAD. If unwilling to become personally involved, this could be by providing a phone number, an information leaflet or website address (for those with online capability) of the Northern Territory's SCENZ-type body. Palliative care/hospice should not be allowed to unilaterally withdraw services from a person because they have applied for VAD.

- Palliative care is a valued medical specialisation in its own right. If possible, funding for it should be increased. Palliative care is not a sufficient substitute for VAD as our NZ reports show: 77% of VAD applicants were already receiving palliative care at the time of their application. NZ's standard of palliative care is high. Both services are necessary.

- Regular legislative reviews should be incorporated into the Northern Territory's VAD Act to allow later for tweaking of the legislation in line with feedback from users of the service, practitioners and the wider public. In NZ, an initial legislative review is legislated to take place 3 years after the coming into force of the Act and then at least every 5 years thereafter.

- We recommend bearing in mind that health service consumers make legal life-ending decisions every day; for example, a decision to decline life-saving treatment or blood transfusions, to reject medication, to stop eating and drinking. These decisions require no scrutiny by parliament. It is therefore advisable that VAD legislation not be overly-complicated. In all cases, the disease or condition will be incurable and well advanced. In all cases, the person will be experiencing unbearable suffering. The Act is remarkably concise by comparison with many other pieces of similar legislation, yet perfectly sufficient and safe. Please consider reviewing it as part of your preparation. We are both small territories.

In conclusion, the End-of-Life Choice Society NZ thanks the Northern Territory Government for the opportunity to contribute.

Yours sincerely

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for and on behalf of the End-of-Life Choice Society NZ www.eolc.org.nz