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Legislative Assembly of the Northern Territory
Legal and Constitutional Affairs Committee
Parliament House
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Australia

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Voluntary Assisted Dying in the Northern Territory

Submission by "DIGNITAS – To live with dignity – To die with dignity" Forch, Switzerland

for and on behalf of the 170 Australian members
of DIGNITAS – To live with dignity – To die with dignity
submitted by email to LA.VAD@nt.gov.au

Introduction

The Swiss non-profit membership association "DIGNITAS – To live with dignity – To die with dignity" (hereafter abbreviated "DIGNITAS" for easier reading and writing) provides this brief submission in response to the consultation on voluntary assisted dying in the Norther Territory[1], based on its work of 27 years. This includes know-how and experience from conducting over 4,100 cases of physician-supported assisted/accompanied suicide (PSAS) in line with Swiss law, including three individuals from the Northern Territory amongst 45 individuals from Australia[2].

The reason for providing this submission is obvious from the aims and further information available on the website of DIGNITAS[3]: for many years, DIGNITAS has, besides other work, focussed on implementing and safeguarding the human right and freedom of individuals to decide on the time and manner of their own end in life – which includes having the choice of voluntary assisted

1 https://parliament.nt.gov.au/committees/list/legal-and-constitutional-affairs-committee/VAD.
2 http://www.dignitas.ch/index.php?option=com_content&view=article&id=32&Itemid=72&lang=en.
3 E.g. "The basic information at a glance and a 'click': on http://www.dignitas.ch/index.php?lang=en.

dying (VAD) – and to have access to professional help to put this into practice in a legal and safe way at their home, surrounded by their loved ones.

This submission does not cover all of the questions raised in the Consultation Paper. Without doubt, the Northern Territory Voluntary Euthanasia Society and further relevant Australian end-of-life-choices advocacy groups will provide in-depth submissions and, moreover, valuable experience on the merits and flaws of VAD legislation in other parts of Australia. If the Legal and Constitutional Affairs Committee chooses, they may also like to refer to DIGNITAS' earlier submissions on consultations for legalising VAD[4].

DIGNITAS is happy to give further evidence, personal, oral and written, if the consultation committee wishes, as DIGNITAS already did in other consultations on VAD in Australia and elsewhere. They are also welcome to visit DIGNITAS.

Making VAD legal in the Northern Territory

DIGNITAS supports making voluntary assisted dying legal in the Northern Territory. So do a majority of the people, as the Voluntary Assisted Dying Final Report 2024 notes: "Overwhelmingly, the Panel's consultations demonstrated the community supports the return of VAD legislation". 73% of respondents to a survey found that "A person should be able to choose when they die"[5].

Individuals requesting VAD (and their loved ones) should not have to carry the burden of going abroad to DIGNITAS or being left to turn to lonely do-it-yourself suicides with risky and/or illegal methods, with all the negative consequences thereof for themselves, their loved ones, and third parties.

Alongside this, DIGNITAS and the country of Switzerland should not need to take care of an issue which can be resolved by the countries from which these individuals travel. The aim of DIGNITAS is that the "medical tourism of assisted dying" stops and DIGNITAS becomes obsolete for these people[6].

Importantly, and this is reflected in DIGNITAS' experience, permitting VAD is a way of improving health. Not all of those who obtain access to the choice of VAD will make use of it. In the words of Julian Gardner, Chairperson of the Voluntary Assisted Dying Review Board of the state of Victoria[7], the first Australian state to legalise VAD (after it had been briefly legal in the Northern Territory): "Having some control of the dying process may lift psychological and general health. For many people, having access to medication gives them the option to exercise their autonomy and die on their own terms. Some of those people choose not to have the medicine dispensed and some have the medication and choose not to take it. We know from feedback they do receive comfort from that"[8].

Expanding on his point about lifting psychological and general health, it should be noted that legalising VAD has a preventive effect on do-it-yourself suicide attempts. In the absence of a legal and professionally supported option, some suffering individuals take drastic measures[9], with

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4 E.g. http://www.dignitas.ch/images/stories/pdf/diginpublic/stellungnahme-submission-vadintheact-06042023.pdf; http://www.dignitas.ch/images/stories/pdf/diginpublic/stellungnahme-submission-end-of-life-choices-south-australia-31072019.pdf; http://www.dignitas.ch/images/stories/pdf/diginpublic/stellungnahme-submission-end-of-life-choices-western-australia-23102017.pdf

5 https://cmc.nt.gov.au/media/docs/project-management-office/vad-report-2024.pdf pages 25-26.

6 Cf. "The goal of DIGNITAS", page 19: http://www.dignitas.ch/images/stories/pdf/diginpublic/referat-oat-19022025.pdf.

7 https://www.safercare.vic.gov.au/about/vadrb/members.

8 https://www.theage.com.au/national/victoria/why-some-people-with-euthanasia-drugs-do-not-take-the-fatal-dose-20221207-p5c4d4.html.

9 E.g. https://www.smh.com.au/politics/nsw/terminally-ill-turn-to-tragic-and-horrific-methods-to-end-their-lives-20211010-p58yqv.html; report 'The Hidden Truth' https://features.dignityindying.org.uk/last-resort.

all the dire consequences thereof for themselves, their loved ones and third parties. Furthermore, not only are VAD and suicide (attempt) prevention connected, VAD is also aligned with palliative care. The University Hospital of Lausanne in Switzerland has been conducting PSAS/VAD alongside palliative care for some time and a study into the attitudes of university hospital staff towards in-house PSAS revealed that the expected consequences of more professionals providing suicide assistance would be that the importance of palliative care increased, violent suicides decreased, and, also importantly, patient trust did not decrease[10].

When individuals know there is professional, legal and safe support they can turn to for self-determinedly putting an end to their suffering, so regaining control over their lives, they will less likely resort to do-it-yourself methods to end a situation which they find insupportable. In turning to legal and safe support, they can be offered and supported with *all* options to soothe their suffering and so improve their quality of life. One key factor is lifting the taboo and stigma surrounding the issue of dying, death, suicide and end-of-life-choices including VAD. For this to take effect, educating health care professionals and informing the public is key.

On eligibility criteria

With VAD, the basis should be what the European Court of Human Rights (ECtHR) held in its judgment HAAS v. Switzerland outlined in subheading 3 of an earlier submission by DIGNITAS[11], which is that the individual "…is capable of freely reaching a decision on this question and acting in consequence…" Since it is increasingly acknowledged that an individual has the freedom and right to decide on the time and manner of their own end in life, VAD eligibility criteria should be such that medical professionals or others do not (need to) pass judgement on whether or not someone's suffering fits a medical diagnosis considered to be progressive and/or terminal, nor whether or not the suffering/diagnosis is expected to cause death in a set time estimate. Rather, the criteria should reflect what the individual considers to be an impairment of their quality of life, and then to objectivate the individual's perspective. Therefore, in the context of VAD eligibility, suffering could be defined as the reverse of what in its constitution the World Health Organization (WHO) defines as health: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"[12].

The focus would then be on establishing that the individual requesting assisted dying:

- understands the information relevant to the decision relating to access to VAD and the effect of the decision; *and*
- has reached a voluntary decision without coercion or duress; *and*
- is informed as to their palliative, hospice and other care options, including establishing an Advance Care Directive (Living Will), voluntary palliative sedation, and voluntarily stopping eating and drinking (VSED) – this should include information on the potential negative effects of (unguided) do-it-yourself suicide attempts; *and*
- is able to communicate the decision and their views and needs about the decision in some way, including by speech, gestures or other means; *and*
- has discussed the matter with their loved ones with the aim of avoiding a negative "surprise effect" and impact for those loved ones.

As indicated above, one eligibility criterion which should not be applied in VAD law-making is that of any life expectancy limit. No one, not even the most expert medical professional, is able

[10] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0274597; https://journals.plos.org/plosone/article/figure?id=10.1371/journal.pone.0274597.g001.
[11] http://www.dignitas.ch/images/stories/pdf/diginpublic/stellungnahme-submission-vadintheact-06042023.pdf page 7.
[12] https://www.who.int/about/governance/constitution.

to predict the future and to *know* whether a patient will still be alive in six, twelve or any other number of months. There may be life expectancy *estimates* based on experience with the illness/diagnosis given; however, there is also the experience of exceptions. As a result, the criterion of a certain limited life expectancy is a hypothetical one, and it leads to arbitrariness and inequality: someone may hold the opinion that the patient is going to die within six months, but someone else may estimate this to be six months plus one day.

Some claim the criterion of a limited life expectancy to be a "safeguard". The opposite is the case. Individuals who do not meet this eligibility criterion and are deprived of VAD, in their despair could resort to risky do-it-yourself suicide attempts as outlined above or they might turn to DIGNITAS. Both outcomes are obviously undesirable. The limited life expectancy criterion is a copy-paste from the now over 25-year-old and outdated Death with Dignity Act of the State of Oregon in the USA. Most European assisted dying legal frameworks, like Belgium, the Netherlands, Luxembourg, Switzerland (with the longest-standing professionally medically assisted dying practice of over 35 years) and Germany, do not have such restrictive criterion. And in some places which have this criterion, discussions are rising to do away with it[13].

Linked to the limited life expectancy criterion is the one that the individual would need to be diagnosed with a "terminal" illness. This criterion should not be applied in the Northern Territory VAD legislation, for the same reasons as outlined above in regard of the limited life expectancy criterion. To repeat: the central consideration should be what the individual considers to be quality of life. It should be noted that there are individuals who struggle with health conditions that inflict just as much suffering as a condition which is considered to be progressive and/or is reasonably expected to cause death. For example, individuals such as the late PAUL LAMB who was paralysed from the neck downwards after an accident, and fought in the UK courts to obtain access to assisted dying[14]. As to Australia in general, there are still individuals who turn to DIGNITAS[15]: this indicates that the eligibility criteria put in place in other parts of the country so far are too restrictive.

In the context of mental health criteria, two aspects are to be noted:

First, it needs to be remembered that, in principle, people who are of age are assumed to be mentally competent unless there are indications that their mental capacity is limited or no longer present. This is the basis in common law which recognises – as a "long cherished" right – that an adult is presumed to have decision-making capacity unless shown otherwise[16]. Second, criteria should not exclude from VAD – and as such discriminate against – individuals with psychiatric ailments. In fact, the very applicant before the ECtHR, Mr. HAAS, who brought about the judgment acknowledging the human right/freedom to decide on the time and manner of one's own end in life, was suffering from a psychiatric ailment but not a physical and/or terminal disease[17]. A psychiatric illness may impact a person's capacity to make decisions, such as the one to choose VAD, but it need not.

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[13] E.g. in New Zealand https://www.auckland.ac.nz/en/news/2025/08/17/assisted-dying-thoughts-from-front-line.html.

[14] The case of Paul Lamb (and Tony Nicklinson) was finally referred to the ECtHR, but the ECtHR declared Lamb's complaint inadmissible because the rule of exhaustion of domestic remedies had not been observed. https://hudoc.echr.coe.int/eng?i=001-156476.

[15] http://www.dignitas.ch/images/stories/pdf/statistik-ftb-jahr-wohnsitz-1998-2024.pdf.

[16] Cf the VAD consultation papers of Victoria or the ACT. Also Swiss law is based on the assumption that everybody is assumed to have capacity of judgment unless there are clear signs that such is not the case: see article 16 of the Swiss Civil Code https://www.admin.ch/opc/en/classified-compilation/19070042/index.html#a16.

[17] Case of HAAS v. Switzerland, application no. 31322/07, https://hudoc.echr.coe.int/eng?i=001-102940, outlined in subheading 3 of the submission mentioned in footnote 11.

Sometimes it can be observed, especially amongst opponents of VAD working in the fields of psychiatry and psychology, that it is insinuated that individuals requesting VAD would, up-front, not have capacity. This approach not only tries to turn upside down the legal basis for the presumption of capacity, but it labels and stigmatises people who contemplate end-of-life choices with the negative effects of entrenching the taboo on suicide, on VAD, and on death, and potentially leading these people to not talk to doctors, therapists and their loved ones but "to take matters in their own hands"[18].

As to whether 18 years should be the minimum age for accessing VAD, it can be expected that requests for VAD in the Northern Territory will come forward mainly from individuals aged over 18. In comparison in Switzerland, according to the Federal Office of Statistics analysing the years 2010-14, most PSAS cases took place in the age group 75-84, and overall 94% of the persons concerned were over 55 years old[19]. Yet, there may be cases of younger than 18-year-old individuals with an illness which impairs their quality of life and inflicts grievous suffering to the point of them possibly wishing to have the option of VAD. As the Consultation Paper notes, the assisted dying laws of Netherland (also Belgium) recognise this and allow for under-18s to access assisted dying under specific circumstances[20]. The Northern Territory VAD legislation should take this as an example. A 17-year-old individual may well have capacity to understand the consequences of a diagnosis of a severe illness, whether it is cancer or any other, as well as what VAD implies. Furthermore, if a 17-year-old is permitted to set up and/or have respected an Advance Care Directive including to refuse (further) treatment, which will hasten death if applied, it does not make sense to bar young persons from VAD which leads to the same result.

As to a residency requirement, all discrimination should be avoided. DIGNITAS takes note that the ACT, NSW and Queensland enable a person to apply for an exemption to the local residency requirements under certain circumstances[21]. 69% of respondents to the survey mentioned above (footnote 5) support such an approach. This is positive and it should be expanded on. The issue of potential "medical tourism of voluntary assisted dying" by people from other parts of Australia (if eligibility criteria of the Northern Territory VAD law were more progressive-liberal than in other parts of Australia), or even overseas aiming to access VAD in the Northern Territory should not be solved by installing a restrictive residency requirement, but by engaging in the decriminalisation and/or further development of VAD in other legislations, so that people would not need to consider turning to the Northern Territory. Just as much as they should not need to turn to DIGNITAS in Switzerland.

Yours sincerely
DIGNITAS – To live with dignity - To die with dignity

[redacted]

Ludwig A. Minelli Silvan Luley

[18] Cf. the TEDx talk "Cracking the taboo on suicide is the best means to prevent suicide attempts and deaths by suicide" http://www.dignitas.ch/images/stories/pdf/diginpublic/referat-tedxzurich-08072021.pdf.
[19] https://www.bfs.admin.ch/bfs/en/home/statistics/catalogues-databases/publications.assetdetail.3902308.html.
[20] https://www.government.nl/topics/euthanasia/termination-of-life-for-terminally-ill-children-aged-1-to-12.
[21] Consultation Paper page 20.