Submission of Emeritus Professor Michael Quinlan to the Legal and Constitutional Affairs Committee of the Legislative Assembly of the Northern Territory ("the Committee") Consultation Paper "Voluntary Assisted Dying in the Northern Territory July 2025 (the Paper)

I am grateful to the Committee for the opportunity to make this submission. I was admitted to the legal profession in 1989 and worked at the commercial law firm Allens where I was a partner for more than 14 years. In 2013, I left Allens to take up the role of Professor of Law and Dean of the School of Law, Sydney at The University of Notre Dame Australia (Notre Dame). In 2020 I was appointed Notre Dame's inaugural National Head of the School of Law & Business. On my retirement in December, 2024, I was conferred the title of Emeritus Professor. I am a board member of Freedom For Faith (FFF), a Member of the Guild of Catholic Scholars (the Guild), a Member of the Editorial Advisory Board of the *Australian Journal of Law and Religion* (the *Journal)*, a Member of the Tribunal Financial Funding Group of the Interdiocesan Tribunal of Sydney (the Group) and a Life Member and Vice President of the St Thomas More Society (the Society). Prior to my retirement, in December 2024, I was a long term member of the Legal Profession Admissions Board and the Council of Australian Law Deans. I was also an inaugural member of the advisory board of the Catholic Archdiocese of Sydney's Anti-Slavery Taskforce and the Consultative Committee of the Interdiocesan Tribunal.

This submission is made by me in my personal capacity and not as a representative of Notre Dame, FFF, the Guild, the *Journal*, the Group or the Society.

I have a deep interest in the relationship between law and morality and law and religion. I hold *Bachelor of Laws, Bachelor of Arts* and *Master of Laws* degrees from the University of New South Wales and a *Master of Arts (Theological Studies) (with High Distinction)* degree from Notre Dame. I have written extensively in relation to law and freedom of conscience, belief and religion. My published papers include "How the law in Australia is used and can be used to promote or to harm the Catholic faith",[1] "Religion, Law and Social Stability in Australia,"[2] "Marriage, Tradition, Multiculturalism and the Accommodation of Difference in Australia,"[3] "When the State requires doctors to act against their conscience: the religious implications of the referral and the direction obligations of health practitioners in Victoria and New South Wales,"[4] "Such is Life" Euthanasia and capital punishment in Australia:

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[1] *Catholics and Law Congress*, Turon, Poland, November, 2013 accessible at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2970833

[2] *22nd Annual International Law and Religion Symposium*, Brigham Young University, Provo, Utah, USA, October 2015 accessible at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2970897

[3] (2017) *The University of Notre Dame Australia Law Review*: Vol. 18 , Article 3. accessible at: http://researchonline.nd.edu.au/undalr/vol18/iss1/3

[4] (2016) *Brigham Young University Law Review* 1237 (2017) accessible at: http://digitalcommons.law.byu.edu/lawreview/vol2016/iss4/7

consistency or contradiction?,"[5] "A great nation? The changing place of religion in law and society in colonial and contemporary Australia: reflections on Murray in an Australian context"[6] and "The 21st century Catholic lawyer."[7] My book chapters include: "Taking The Right Way Back: The Truth In An Era Of Challenges to Freedom Of Religion in Australia,"[8] and "Sacrificing Dignity to Protect Dignity: Human Dignity and Exclusion Zones in Australia."[9] I am a regular contributor to *The Catholic Weekly* and *News Weekly* and have also been published in *The Australian*.

The submission begins with the answers to some of the specific questions posed by the Paper followed by a discussion of the issues raised by the Paper. The submission follows the numbering and headings used in the Paper. The submission does not specifically address every topic or question raised in the Paper for consideration. The fact that I do not address a topic or question should not be taken as agreement with the relevant content the Paper.

Answers to consultation questions

1. Introduction

Key questions

1. The NT should not introduce VAD. The unique circumstances of the NT in terms of its own experience of VAD, its vast size, small population and the inadequate availability of palliative, medical and psychiatric care, dignity therapy and access to nursing staff and medical specialists all indicate that VAD, meeting the definition of VAD set out in the introduction to the Paper, could not be achieved. Palliative, medical and psychiatric care and access to medical specialists must first be in place before VAD, meeting the definition of VAD set out in the introduction to the Paper, could be achieved and consideration of legislating VAD should not occur in advance of those improvements.
2. See 1
3. See 1
4. Careful, comprehensive and accessible reporting of VAD would be an essential component of the introduction of VAD.

2. Consultation Topic 1: Legislating VAD in the NT

Question for consideration

The NT should not introduce VAD. The unique circumstances of the NT in terms of its own experience of VAD, its vast size, small population and the inadequate availability of palliative, medical and psychiatric care, dignity therapy and access to medical specialists all indicate that VAD, meeting the definition of VAD set out in the introduction to the Paper, could not be achieved. Palliative, medical and psychiatric care and access to medical specialists must first be in place before VAD, meeting the definition of VAD set out in the

[5] (2016) *Solidarity: The Journal of Catholic Social Thought and Secular Ethics*: Vol. 6: Iss.1, Article 6. accessible at: http://researchonline.nd.edu.au/solidarity/vol6/iss1/6
[6] *St Marks' Review* (2020) 252, 63-78
[7] 16 *Ave Maria Law Review* (2018) 36 accessible at: https://heinonline.org/HOL/LandingPage?handle=hein.journals/avemar16&div=5&id=&page
[8] *Forgotten Freedom No More Protecting Religious Liberty in Australia* (ed Robert Forsyth and Peter Kurti) Connor Court, 2020.
[9] *The Inherence of Human Dignity Volume II: Dignity, Law and Religious Liberty* (ed Barry Bussey, Angus Mengue) Anthem Press, 2020.

introduction to the Paper, could be achieved and consideration of legislating VAD should not occur in advance of those improvements.

Questions for consideration

The Terminally Ill Adults (End of Life) Bill (UK) provides better protections of the vulnerable than VAD laws passed in Australian jurisdiction to date.[10]

The unique circumstances of the NT militate against the introduction of VAD in the NT but, if it were to be introduced, a very specific NT law would need to be formulated. In particular no VAD legislation should become operational ion the NT prior to improvements in palliative, medical and psychiatric care and access to dignity therapy and medical specialists.

3. Consultation Topic 2: Delivering VAD in the NT

Centralised model

Questions for consideration

If VAD is to be introduced in the NT there would be benefits and challenges in adopting a single, centralised service for the delivery of VAD. This could assist to protect others – particularly medical practitioners and pharmacists from being tainted with association with VAD.

A centralised approach in itself may create issues of concern as advocates for VAD may be most attracted to take up those roles. This may result in an actual or, at least, perceived conflict of interest but also fail to ensure that, throughout the process, the full range of options available to patients are fully and dispassionately discussed to ensure that each person who undergoes VAD has really exercised free choice. For those involved in the proposed Care Navigator Service it will be critical that they objectively and without a pro-VAD bias are able to refer "people to other services and resources." They must also be trained in understanding and respecting religious and Aboriginal and Torres Strait Islander perspectives on VAD and not to see their role as promoting VAD exclusively or in a biased way.

Regional access support services

Questions for consideration

The first steps which need to be taken if VAD is to be introduced and the intention is that people in remote and regional communities can access VAD fairly and safely, is first to ensure real access in remote and regional areas to adequate medical and mental health care including specialist diagnosis, dignity therapy and current best practice pain relief and palliative care. The NT should not fund visiting VAD services or introduce VAD without first ensuring these services are in place. To do so would be to introduce VAD services which do not meet the Paper's definition of VAD in the Introduction to the Paper. People who are experiencing pain or mental health issues or who have been misdiagnosed or who are not being provided with access to adequate medical care and palliative care or who have not enjoyed access to dignity therapy may not be freely choosing VAD either because they are not competent to do so or they have been misinformed about their medical condition, their treatment options (and the NT must ensure that treatment options are really available) their likely life expectancy etc or they are depressed or experiencing a treatable suicidal ideation . Introducing VAD first will inevitably results in VAD deaths occurring in fact because of a

[10] Paul Santamaria KC, "UK VAD Bill, As Bad As It Is, Is Still Better Than Ours," *News Weekly* No 3193, July 12. 2025, 14-15

failure to adequately provide other services. Not only should VAD not be "a way for a person who is not terminally ill to end their life" it should not be a way for a person who is not being provided with access to proper medical care to tend their life. If so the Territory would be responsible for such premature deaths.

Guidance for Aboriginal and Torres Strait Islander people.

Questions for consideration

Any introduction of VAD in the NT would require respect for cultural differences which should not simply be classified as "challenges." A more communitarian approach respecting family and kinship is not wrong or a properly characterised as a "challenge." The fact is that, the death of a person has impacts beyond the individual – it impacts family, friends and the community. Information providing guidance to Aboriginal and Torres Strait Islander people should not be limited to information about VAD or options for assistance to returning to Country (if this can in fact be provided safely to others) but include information about access to specialists for appropriate advice, medical and palliative care options, dignity therapy etc

4. Consultation Topic 3: Eligibility

Minimum age

Question for consideration

If VAD is introduced in the NT, 18 would be an appropriate minimum age.

Residency

Question for consideration

The NT should not facilitate forum shopping or "VAD tourism."   If VAD is introduced in the NT residency in the NT for 12 months prior to seeking access to VAD or who have lived for a substantial period of their life in the NT.

Eligible condition

Questions for consideration

The longer the period of prognosis the greater the risk of error. A 6 month or shorter period of prognosis of death from physical illness from a terminal illness should be required. Patients must have real access to best practice pain relief and other medical care so that their decision making is not impaired and that they do not opt for VAD in circumstances where the cause is poor treatment.

Decision-Making capacity

Questions for consideration

The longer the period of prognosis the greater the risk of error and the greater potential for medical progress to occur before death. There should not be special rules to facilitate access to VAD for those living with progressive illnesses.

Protections for those seeking VAD need to include assessment of their mental health and a determination by a psychiatrist – in consultation with the patient's GP and with access to their medical history - that they are not suffering from treatable depression or another mental health condition – is a worthwhile protection.

Any introduction of VAD in the NT would require respect for cultural differences. A more communitarian approach respecting family and kinship would be a worthwhile inclusion for all Territorians.

5. Consultation Topic 4: VAD Process

Health professionals who do not want to help with VAD

Questions for consideration

Health practitioners with a conscientious or religious objection to VAD should not be required to participate in any way with VAD including by providing information to a centralised VAD service.

All persons who may be involved in VAD should have their freedom of conscience and religion protected not just registered health practitioners.

Health practitioners are entitled to privacy in relation to their beliefs. They should not be required to disclose their beliefs to persons interested in accessing VAD. If those with conscience or religious objections to VAD where required to make disclosures of that kind to their patients, the same should be required of those who support VAD and euthanasia.

Health services which form part of a religious tradition which considers VAD to be immoral should not be required to permit VAD on its premises.

Palliative care services

Questions of consideration

Health care professional should be required to provide information on the range of medical treatments for their condition (including referrals for second opinions on prognosis and diagnosis), pain relief options, dignity therapy and palliative care if a person requests VAD.

More resources should be provided for community education on palliative care.

VAD should not be introduced before adequate palliative care is available across the NT.

All patients diagnosed with a terminal illness – and absolutely essentially those considering VAD – must have access to specialist palliative care ad advice from a specialist in palliative care.

Notifying and registering a person's death

Questions for consideration
VAD should be recorded as the cause of death on death certificates where the death is a result of VAD.

6. Consultation Topic 5: Oversight and Review

Review Board

Questions for consideration
The Review Board must, as the Paper suggests, "reflect the geographic and cultural diversity of the Territory." It should include mental health experts, palliative care specialists, pain management experts, lawyers and bioethicists.

The Review Panel should be prospective and review and approve applications in advance in every case. As death is irrevocable, it is too late for the Review Board to identify an error after a person has died by VAD where that death might have been avoided, by example, by ensuring specialist diagnoses and prognosis, treatment, dignity therapy, pain management and palliative care options.

Reviewing eligibility decisions

Questions for consideration
Decisions which should be reviewable by the NCTCAT should include not only the reviewable decisions, set out in the Paper to align with other Australian jurisdictions, but also eligibility, that is, the accuracy of diagnosis and prognosis and the quality of information provided on pain relief, treatment, dignity therapy and palliative care options.
The timing that generally applies for appeal to NCTCAT of 28 days appears appropriate.
Family members and those other persons who have a sufficient and genuine interest in the rights and interests of the person seeking VAD should have standing to seek review of VAD decisions.

Reviewing the operation of legislation

Questions for consideration
A review after two years of commencement and then after every three years would be appropriate in the circumstances.

The review should consider the adequacy of palliative care and pain management in the NT as well as the compliance and operation of VAD.

Implementation timeframe

Questions for consideration
VAD should not become operational in the NT until 18 months after the adequacy of medical treatment including mental health care and access to dignity therapy for those seeking VAD, palliative care and pain management is in place.

Discussion of the issues raised by the Paper

1.Introduction

What is Voluntary Assisted Dying (VAD)?
The Paper helpfully begins with a definition of VAD, which uses some key terms which warrant very careful consideration, and to which the Committee should give very careful consideration in making its recommendations. I comment on them below:
"terminally ill" – a person must **actually** be terminally ill in this definition. The definition does not refer to a person who has been *diagnosed* with a terminal illnesses but to a person who is actually terminally ill. This necessitates access to correct and accurate medical diagnosis.
"choice" – a person must have access to relevant information to really be able to exercise a choice and in this context must have access to a correct and accurate diagnosis, access to appropriate treatment (including palliative care, and, where relevant, psychiatric and psychological care, dignity therapy and appropriate pain relief and) and must not be subject to coercion.
"freely chosen" and "competent" – a person suffering from pain, mental illness or coercion may not be said to be making a "free" choice or "competent" to do so. The same issues arise as with "choice"
"continuing treatment for an illness or palliative care" – this necessitates the availability and access to appropriate treatment and palliative care.

Context
The Paper mentions the fact that VAD is not currently legal in the Northern Territory (NT) and that it was briefly legal in the 1990s. It does not address the issues raised by the NT experience of that legislation during the period in which it operated. I will briefly address those below. The paper also mentions the *Report into Voluntary Assisted Dying in the Northern Territory* (2024 Expert Panel Report) and attaches the Terms of Reference. The final Term of Reference makes clear that the Committee is to consider whether VAD should be reintroduced in the NT at all and, only if, it concludes that it ought to be adopted consider what terms VAD legislation might take if enacted in the NT. However the key questions and questions for consideration, raised in the Paper, and the Consultation Topics appear to assume that VAD should be reintroduced into the NT. Yes, Consultation Topic 1 does ask for consideration of personal support for legislating VAD in the NT but this assumes that support or opposition to VAD, in the NT, is merely a matter of personal preference. Other than a request for submissions to disclose the personal position of submitters on legislating VAD in the NT, all of the other questions posed in the Paper relate to the specifics of VAD legislation which pre-supposes that the Committee will conclude that VAD legislation should be implemented. There is no consideration in the Paper, or questions asked, which specifically address the issues that legalising VAD generally gives rise to nor as to what gives rise to requests for VAD. Whilst other States and Territories in Australia have introduced VAD, there are particular unique circumstances of the NT – not least of which is its own history with VAD - which militate against VAD in the NT.

Key questions

1. The NT should not introduce VAD. The unique circumstances of the NT in terms of its own experience of VAD, its vast size, small population and the inadequate availability of palliative, medical and psychiatric care and access to medical specialists all indicate that VAD, meeting the definition of VAD set out in the introduction to the Paper, could not be achieved. Palliative, medical and psychiatric care and access to medical specialists and dignity therapy must first be in place before VAD, meeting the definition of VAD set out in the introduction to the Paper, could not be achieved.
2. See 1
3. See 1
4. Careful, comprehensive and accessible reporting of VAD would be an essential component of the introduction of VAD.

2. Consultation Topic 1: Legislating VAD in the NT

Views on VAD

Before addressing issues specific to the NT in the context of VAD, I will set out some general considerations and issues with the practice.

VAD is a recent phenomenon and remains rare in the world

Whilst VAD has been legislated, in recent years, in the other Australia States and Territories this, in itself, does not mean that it is appropriate for the NT or that the NT is an outlier jurisdiction internationally. As will be discussed below, the NT is different from other Australian States and from the ACT. Euthanasia was not recognised as medical treatment for 2,400 years.[11] Assisted dying remains prohibited, in most of the world, being permitted only in some European countries, Colombia, New Zealand, Canada and some US States. [12] The House of Commons in the UK recently passed the Terminally Ill Adults (End of Life) Bill (the UK VAD Bill) which awaits consideration by the House of Lords. This UK VAD bill includes significant differences to legislation, which has passed in Australia, including more and better safeguards.[13]

Death is irrevocable: danger of misdiagnosis, inadequately information re options etc

Every person is part of a family, a community and a place. Every death of a person brings to an end that person's interactions with others, advice giving, storytelling and shared experiences. It is obvious but important, in the context of VAD, to recognise that death is irrevocable. If an individual opted for VAD when misdiagnosed, inadequately informed about treatment or palliative care options or indeed not having those options available, suffering from untreated pain, lacking the mental capacity to consent, suffering from an untreated illness particularly a mental illness, such as depression or a suicidal ideation which may respond to dignity therapy or when overborne or pressured by another not only can the death not be considered a voluntary, free choice but it is irrevocable. The deceased cannot return to life even if those failings are later discovered. The longer the period

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[11] Margaret Somerville, *Bird on an Ethics Wire* (Mc-Gill Queen's University Press,2015) 166

[12] World Federation of Right to Die Societies, "World Map:" https://wfrtds.org/worldmap/

[13] Paul Santamaria KC, "UK VAD Bill, As Bad As It Is, Is Still Better Than Ours," *News Weekly* No 3193, July 12. 2025, 14-15

allowed before predicted death in the prognoses allowed for VAD, the longer the greater the lost interactions in cases of error.

Understanding the motivation of those who opt for VAD and suicidal ideation
The definition of VAD, given in the Paper makes it clear that there is intended to be a clear differentiation between VAD and suicide. The definition notes that "VAD is not a way for a person who is not terminally ill to end their life." This suggests that those who ought to be permitted to access VAD have some unique motivation for dying which differs from members of society who otherwise seek suicide. If that is not so, the maintenance of any meaningful distinction between (State sanctioned and legally permitted) VAD and suicide (which remains discouraged and for which treatment for suicidal ideation remains intended to be accessible) breaks down. The reality is, that the motives of VAD applicants align with those experiencing suicidal ideation in general. In their study of terminally ill cancer patients, Ruijs et al found that the presence or absence of unbearable symptoms or unbearable suffering in patients, was not a significant indicator of an explicit request for VAD. The motives for seeking VAD, which were most frequently mentioned, were instead existential concerns. These included a perceived "loss of control, loss of autonomy, loss of dignity, not wanting to be a burden to others and fear of the future."[14] These existential concerns are concerns which are not isolated to those who are terminally ill and close to death. They are also found in others, in the general community, including those experiencing a suicidal ideation or suffering from depressive illnesses. For example, some common causes of suicidal ideation, in the general community, include "feeling or appearing to feel trapped or hopeless", "feeling intolerable emotional pain," "increased isolation", "talking about being a burden to others" and "talking about suicide or dying, expressing regret about being alive or ever having been born."[15] Such conditions are treatable. We do not treat existential fears in the general population by assisting suicide or euthanasia so why that should be considered an appropriate response to their existence in the terminally ill is unclear. It is also unclear how if indeed the NT were to embrace VAD as an appropriate treatment for suicidal ideation in the terminally ill, it could logically seek to continue to discourage suicide in the general population for such reasons. One method of treating these sorts of issues in the terminally ill which has proved very successful is 'dignity therapy.' Below is a summary of Dr Chochinov's dignity therapy approach and of the findings of his research into the outcomes of applying the approach:

> … Terminally ill inpatients and those receiving home-based palliative–care services were asked to complete pre- and post-intervention measures of sense of dignity, depression, suffering, and hopelessness; sense of purpose, sense of meaning, desire for death, will to live, and suicidality; and a post intervention satisfaction survey. Ninety-one per cent of participants reported being satisfied with dignity therapy; 76 per cent reported a heightened sense of dignity; 68 per cent reported an increased sense of purpose; 67 per cent reported a heightened sense of meaning; 47 per cent reported an increased will to live; and 81 per cent reported that it had been or would

[14]Cees DM Ruijs, Gerrit van der Wal, Ad JFM Kerkhof, and Bregje D Onwuteaka-Philipsen "Unbearable suffering and requests for euthanasia prospectively studied in end-of-life cancer patients in primary care," (2014) 13 BMC Palliative Care 62 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4292985/
[15] Christian Nordqvist "What are suicidal thoughts?" Medical News Today 13 February 2018 https://www.medicalnewstoday.com/kc/suicidal-thoughts-ideation-193026

be of help to their family. Post-intervention measures of suffering showed significant improvement and reduced depressive symptoms. Finding dignity therapy helpful to their family correlated with life feeling more meaningful and having a sense of purpose, accompanied by a lessened sense of suffering and increased will to live.[16]

Focussing on methods of addressing the underlying concerns of those who seek VAD whether they be they improved pain management, accessible and high quality palliative care, , rectifying poor quality nursing home conditions or assistance in addressing loneliness, feelings of hopelessness or of being a burden on others are all available actions which the NT might take which do not involve embracing VAD. These should be explored and guaranteed, before reintroducing VAD, particularly in light of the unique circumstances of the NT.

Unique Circumstances of the NT

Distance, Population, Disease Profile, Health, Palliative and Aged Care inaccessibility

The Paper mentions some of the challenges that face the NT. More detail of the issues that face the NT are set out in the 2024 Expert Panel Report.[17] It notes the high burden of disease, the relatively small population, "considerable challenges in delivering health care" and challenges in the provision of palliative care and aged care. However neither the 2024 Expert Panel Report nor the Paper identify these issues as militating strongly against introducing VAD in the NT. People in pain want that pain to stop. Death can seem desirable when in pain.[18] Today it is only in a small percentage of cases that suffering and pain cannot be relieved by high quality palliative care.[19] Many VAD candidates change their mind when provided with pain relief and palliative care.[20] For example, an Oregon study found that nearly half of those requesting VAD changed their mind when they were treated for pain or depression or referred to a hospice.[21]

Adequate training of physicians in pain management and access to such services are issues in Australia.[22] They are likely to be even more significant issues in the NT than the rest of the nation. A failure to appropriately control a patient's pain or to provide access to palliative care can result in requests for VAD which cannot properly be termed voluntary.[23] The

[16] Harvey Max Chochinov, *Dignity Therapy* (OUP, 2012) as quoted by Margaret Somerville, " Margaret Somerville: Dr Harvey's must-read book unpacks what dignity means" *Catholic Weekly* 8 June 2017
[17] 2024 Expert Panel Report 21,22
[18] Somerville, *Bird on an Ethics Wire* 138
[19] Hal Swerissen and Stephen Duckett, "Dying Well" Grattan Institute Report No 2014-10 (2014) 2,15. See discussion in Adhar" The Case Against Euthanasia and Assisted Suicide" 31-33
[20] Somerville, *Bird on an Ethics Wire* 128.
[21] Standing Committee on Legal and Constitutional Affairs," Report of the Standing Committee on Legal and Constitutional Affairs Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008" (June 2008) 44 [4.44]
[22] Margaret Somerville, Dr Brian Pollard and others have noted that pain control has been available to deal with pain across a wide spectrum of diseases for decades but that most doctors are poorly educated in the area. Swerissen and Duckett identify deficiencies with the availability of palliative care in Australia: Swerissen and Duckett, "Dying Well" esp.17-19
[23] Somerville and others argue that those in pain have a "fundamental human right" to reasonable access to pain management: Somerville, *Bird on an Ethics Wire* 235-240

experience of the American, Sidney Cohen is illustrative. After being diagnosed with cancer, Mr Cohen was bed-ridden, suffering agonizing pain and he had been given a prognosis of three months to live. Whilst in this situation Mr Cohen asked for euthanasia. As euthanasia was illegal instead of being euthanised he was placed into hospice home care. Eight months later Mw Cohen was enjoying a full life and opposed to euthanasia.[24] Mr Cohen's experience is not unique. In her book *Death Talk* Margaret Somerville tells the story of her own father's death. She describes being telephoned from Australia and told that her father was in his final days. On arrival she found him in great pain and incoherent. He told her that he wanted to live as long as he could but not with such terrible pain. She insisted on his being seen by a pain specialist. Following a change to his pain relief his lucidity returned and he lived almost pain free for a further nine months.[25]

Without adequate health care, accessibility to pain management, availability of palliative care, access to dignity therapy and to quality aged care, there is too great a risk that those who opt for VAD will not be exercising a real choice. Rather than their terminal illness, it is the circumstances in which they find themselves, from which they seek escape. The risk of misdiagnosis is also exacerbated where specialists are in inadequate supply.

History of legislating VAD

The Paper notes that the NT has experience with VAD under the *Rights of the Terminally Ill Act 1995* (NT) (*ROTI Act)*. It does not mention that that experience, of the actual operation of VAD in the NT, itself has been the subject of academic study. That research warrants careful review in any review of the possibility of reintroducing VAD in the NT in 2025. It should not make anyone feel comfortable with the efficacy of legislated safeguards in the specific context of the NT. In the brief period in which the *ROTI Act* operated, 2 out of the 7 patients who sought euthanasia were provided with inadequate information of their true medical condition and of their treatment options.[26] Under the *ROTI Act,* if a doctor found that the patient did not meet the criteria for access to euthanasia, the patient (of his or her advisers) could approach an unlimited number of other doctors until one could be found who would give the required opinion.[27] This situation arose during the brief operation of the *ROTI Act* in Case 4. When there was no consensus among oncologists as to whether the patient's condition satisfied the *ROTI Act's* requirements, the patient made an appeal on national television. An orthopaedic surgeon, who had no expertise in her condition as the *ROTI Act* required, provided the certification that the patient's condition was terminal and she was euthanised.[28] In Kissane's opinion:

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[24] Visnja Srinic," Arguments in Support and Against Euthanasia" (2015) 9 *British Journal of Medicine and Medical Research* 7 1-12, 4.

[25] Margaret Somerville, *The Ethical Canary* (Penguin, 2000) 138-139

[26] Kissane, Street and Nitschke "Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia":1098-1101

[27] This feature of patients seeking multiple opinions similarly forms part of the process recommended for Canada by the College of Physicians and Surgeons of Ontario at the various stages of the process – from the first request to the second consulting physician: College of Physicians and Surgeons of Ontario Policy Statement #1-16, 6-7.

[28] Kissane, Street and Nitschke "Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia." 1100,1101; David W. Kissane, "Case Presentation: A Case of Euthanasia, The Northern Territory, Australia," (2000), 19 *Journal of Pain and Symptom Management* 6, 472

> The voluntariness of her choice for euthanasia was influenced by her not being informed of the availability of effective treatment for depression nor being given the opportunity to have her suffering alleviated.[29]

In Case 5 a patient was jaundiced and suffering from a bowel obstruction but was not advised of the palliative care[30] and medical treatment available.[31] In Kissane's view:

> Given the level of error rate that does occur in medical practice, this experience [of the operation of the ROTI *Act*] suggests it would be impossible to safely legislate for doctors to kill.[32]

Psychiatric illnesses and depression raise issues about a patient's mental capacity to provide informed consent.[33] These conditions also raise issues about access and adequacy of treatment as most patients respond to treatment.[34] Studies have established the association between depression and a wish to die and that appropriate treatment often sees the wish to die disappear.[35] Of the 7 patients, who sought to access euthanasia under the *ROTI Act,* 4 showed symptoms of depression.[36]

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[29] David W. Kissane, "The Challenge of Informed Consent," (2000), 19 *Journal of Pain and Symptom Management* 6, 473

[30] Palliative care is "care that provides coordinated nursing, medical and other allied services for people with a terminal illness." Standing Committee on Legal and Constitutional Affairs," Report of the Standing Committee on Legal and Constitutional Affairs Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008" (June 2008) 42 fn 55

[31] Kissane, Street and Nitschke "Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia." 1100. Although this was required by s7(1)(e) of *the NT Act*

[32] D.W. Kissane, "Submission 589" quoted by Steve Fielding "Statement by Family First" 82 [1.6]

[33] Levene and Parker argue that: "Depression is a concern in requests for euthanasia/PAS because it is potentially reversible and may affect the patient's competency, particularly in the relative weighting they give to positive and negative aspects of their situation and possible outcomes. Depressed patients can be viewed as a vulnerable population in this context as their request for death may be part of their illness, with the correct response being treatment rather than assistance in dying.": Levene and Parker, "Prevalence of depression in granted and refused requests for euthanasia and assisted suicide: a systematic review" 205. Emmanuel et al observe that: "psychological distress including depression and hopelessness, are significantly associated with patients' interest in hastening their own death through euthanasia and/or PAS." E Emmanuel et al "Depression, euthanasia and improving end-of-life care" (2005) 23 *Journal of Clinical Oncology* 27, 6456 as quoted by Fielding "Statement of Family First" 84 [1.17]

[34] RANZCP New Zealand National Committee, "Submission to Health Committee investigation into ending one's life in New Zealand." 2, 3. This is a particular concern because many current and proposed euthanasia regimes permit access to patients whose sole illness is a psychiatric one. For example, California's 2015 *End of Life Option (Physician Assisted Suicide).* Similarly, the criteria to be applied in the Canadian regime, which the *Carter* decision requires be in place by June 6, 2016, does not limit its operation to physical ailments. It requires that the candidate be a consenting, competent adult with "a grievous and irremediable medical condition (including an illness, disease or disability) and "[e]xperience enduring suffering that is intolerable to the individual in the circumstances of his or her condition." See discussion in College of Physicians and Surgeons of Ontario, Policy Statement #1-16 "Interim Guidance on Physician- Assisted Death" 3-4.

[35] Kissane, Street and Nitschke "Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia." 1101and fns 11 to 16; Linda Ganzini, Elizabeth R Goy and Steven K Dobscha, "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey" (2001) 337 *British Medical Journal* 1682; Ilana Levene and Michael Parker, "Prevalence of depression in granted and refused requests for euthanasia and assisted suicide: a systematic review" (2011) 37 *Journal of Medical |Ethics* 205-211,205,209, *Washington v Glucksberg* 521 US 730-731.

[36] Kissane, Street and Nitschke "Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia." 1101

Many studies confirm the prevalence of depression among those seeking euthanasia or VAD.[37] Not being trained in the detection of mental illness non-specialists may not appreciate the difficulty of detection.[38] As a result, there are real risks of a lack of diagnosis particularly by non-psychiatrically trained doctors.[39] For example, in 2005 Dr Nitschke observed, in relation to identifying depression in candidates for euthanasia, that "common sense is a good enough indicator. It's not that hard to work out whether you are dealing with a person who is able to make rational decisions or not."[40] However the reality is, that diagnosing major depression in gravely ill patients is extremely difficult.[41]Diagnoses of mental competence are made particularly difficult for doctors who are not psychiatrically trained where patients experience delirium, dementia, addiction or traumatic brain injury.[42]

Even where legislation mandates a psychiatric assessment,[43] prior to accessing VAD, depressed patients remain at risk. Psychiatrists who have a true doctor/patient dialogue as part of a properly multidisciplinary team aimed at assessing and providing appropriate care to a patient are able to assist those afflicted by depression and other forms of mental illness. However, that is not the relationship established when physiatrists are acting as gatekeepers to assess the capacity of a candidate for VAD. Part of the problem is that depressed patients, who have determined to seek VAD, and see any mandated psychiatric assessment as an impediment to obtaining that outcome, are unlikely to disclose their full histories to a psychiatrist. For example, during the operation of the *ROTI Act* one candidate, who was alienated from one child and had endured the death of another, withheld that

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[37]Physician Assisted Suicide. An Oregon study of 58 patients who had requested assistance in dying found that 3 of the 18, who were approved to be assisted to die, were suffering from undiagnosed but treatable clinical depression at the time they were assessed as being suitable candidates for doctors' assistance to die: Ganzini, Goy and Dobscha, "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey" 1682. Oregon's *Death With Dignity Act* only requires a patient to be referred to a psychologist or psychiatrist if a concern exists that the patient's judgment may be impaired by a psychiatric disorder including depression. Studies in the US and Canada found 50-55% of those seeking euthanasia/PAS were suffering from "severe depression or depressed mood" or diagnosed depression: In studies conducted in the Netherlands "severe depression" was identified in 4-47% of people requesting euthanasia/PAS, 2-10% of those whose request for euthanasia/PAS was granted were classified as depressed and 5-25% or people granted euthanasia described depression as a motivating factor in their request. A Swedish study also found a high level of apparent depression in granted PAS requests: Levene and Parker, "Prevalence of depression in granted and refused requests for euthanasia and assisted suicide: a systematic review" 206-208.

[38] Ganzini, Goy and Dobscha, "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey" 1682.

[39] Ryan "Depression, decisions and the desire to die" 411; see also Ganzini, Goy and Dobscha, "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey" 1682.

[40] Dr Philip Nitschke quoted by Steven Fielding, "Statement of Family First" 84 [1.15]. Ganzini, Goy and Dobscha found that family members, physicians and hospice professional of patients who sought to access physician assisted suicide in Oregon did not believe that depression influenced choices to seek to access the legislation: Ganzini, Goy and Dobscha, "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey" 1682.

[41] C Ryan "Depression, decisions and the desire to die" (1996) *Medical Journal of Australia* 165, 411; see also Ganzini, Goy and Dobscha, "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey" 1682

[42] RANZCP New Zealand National Committee, "Submission to Health Committee investigation into ending one's life in New Zealand." 2

[43] with the aim of protecting those suffering from clinical depression or other forms of mental illness, as the *NT Act* sought to do.

relevant information from the psychiatrist charged with her assessment. She was subsequently euthanised.[44] Kissane concluded that "the gatekeeper roles designed by [the *ROTI Act*] failed to protect depressed, isolated and demoralized patients."[45] He noted that of the seven people who sought VAD under the *ROTI Act* 3 were socially isolated and 4 had displayed symptoms of depression.[46]

The impact of VAD on the vulnerable is not measured simply by numerical analysis. As VAD deaths represent a small number of total deaths in those places where it has been introduced[47] adverse impacts on the vulnerable seeking medical attention and any dampening of palliative care resourcing may impact greater numbers of the vulnerable.[48] One death by VAD in an aged care facility may result in more residents seeking VAD. Many indigenous organisations have expressed concerns about the impact of euthanasia on Aboriginal health.[49] There is anecdotal evidence of fear of euthanasia causing indigenous patients to leave hospital and refuse immunisations during the operation of the *ROTI Act*.[50]

VAD appears to similarly impact disproportionately on the vulnerable, those suffering from mental illness, the elderly, the poor and indigenous Australians. There is evidence that vulnerable groups are more likely to be euthanised.[51] Such people may feel they are a

[44] Kissane, Street and Nitschke "Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia." 1101, Kissane, "The Challenge of Informed Consent," 473
[45] D.W. Kissane, "Submission 589" quoted by Steve Fielding "Statement by Family First" 82 [1.6]
[46] Kissane, Street and Nitschke "Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia." 1098, 1100
[47] See Table 1 in the Paper
[48] Strinic, "Arguments in Support and Against Euthanasia"5, 8.
[49] Standing Committee on Legal and Constitutional Affairs," Report of the Standing Committee on Legal and Constitutional Affairs Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008" (June 2008) 35 [4.1.2],52-53 [4.74]-[4.77]. Indigenous concerns about the *ROTI Act* were also aroused by its contradiction of indigenous cultural law and this concern was expressed in a "Letter Strick" delivered to the Commonwealth Parliament by the Yolnu Nation/States within East Arnhem land: Quirk, "Euthanasia in the Commonwealth of Australia" 425 fn22
[50] Standing Committee on Legal and Constitutional Affairs," Report of the Standing Committee on Legal and Constitutional Affairs Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008" 58 [4.98]. Note however that a report prepared in 1997 indicated that there was no evidence from patient travel data or hospital separations the *ROTI Act* affected the willingness of Indigenous Australians to attend hospitals for treatment: Standing Committee on Legal and Constitutional Affairs," Report of the Standing Committee on Legal and Constitutional Affairs Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008" 59 [4.103]
[51]RANZCP New Zealand National Committee, "Submission to Health Committee investigation into ending one's life in New Zealand." 4. This Submission notes that the highest suicide rate in New Zealand is of men aged 85 or above. An Oklahoma programme which operated between 1977 and 1982 made use of a "quality of life" formula in assessing which babies born with spina bifida should "be allowed to live. Poorer children were given a more negative outlook than wealthier children and 24 babies died. Diane Coleman, "Not Dead Yet" in K Foley and H Hendin (ed) *The Case Against Assisted Suicide* John Hopkins University Press, 2002, 229. A 2007 report which looked at evidence from the experience of PAS in Oregon and euthanasia and PAS in the Netherlands concluded from robust data that there was evidence of people with AIDS dying at a disproportionate rate from euthanasia but found that this was not true of the elderly, women or the uninsured. As the report observed it did not consider the impact of access to euthanasia or PAS to minority or vulnerable groups. The analysis was also limited to a consideration of the proportion of those euthanised from particular identified groups rather than a consideration of the broader risks to the vulnerable: Margaret P Battin, Agnes van der Heide, Linda Ganzini, Gerrit van der Wal and Bregje D Ontuteaka-Philipsen," Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in "vulnerable" groups (2007) 33 *Journal of Medical Ethics* 591-597

burden to their families or to society as a whole[52] and that is a real problem with VAD. People should **never** feel that they are a burden and certainly not that they are a burden such that it would be better for others if they opted for VAD.

Overall, the experience of the operation of the *ROTI Act* militates against introducing VAD in the NT.

Religion, VAD and the NT

In the last census, the NT was one of the most religious places in the country having the second lowest number of respondents to identifiy No Religion as their religious affiliation.[53] Most religions prohibit or disapprove of euthanasia. [54]

Question for consideration

The NT should not introduce VAD. The unique circumstances of the NT in terms of its own experience of VAD, its vast size, small population, religiosity and the inadequate availability of palliative, medical and psychiatric care and access to medical specialists and to dignity therapy all indicate that VAD, which is really a free and informed choice not be achieved. Palliative, medical and psychiatric care and access to medical specialists and to dignity therapy must first be in place before VAD, meeting the definition of VAD set out in the introduction to the Paper, could not be achieved. Further consideration of legislating VAD should not occur in advance of those improvements.

Legislative frameworks in other jurisdictions

The NT has significant differences from other Australian States and Territories. This necessitates caution in considering VAD Acts from those States and Territories as providing sound models for the NT. The UK VAD Bill provides better protections of the vulnerable than VAD laws passed in Australian jurisdiction to date.[55] The unique circumstances of the NT militate against the introduction of VAD in the NT but if it were to be introduced a very specific NT law would need to be formulated.

Proposed legislative framework in the NT (2024)

Questions for consideration

The UK VAD Bill provides better protections of the vulnerable than VAD laws passed in Australian jurisdiction to date.[56]

The unique circumstances of the NT militate against the introduction of VAD in the NT but if it were to be introduced a very specific NT law would need to be formulated. In particular no VAD legislation should become operational ion the NT prior to improvements in

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[52] Standing Committee on Legal and Constitutional Affairs," Report of the Standing Committee on Legal and Constitutional Affairs Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008" (June 2008) 57-58 [4.94]-[4.97] [4.1.2],52-53 [4.74]-[4.77]

[53] Australian Bureau of Statistics, "Religious affiliation in Australia" 4 July 2022 https://www.abs.gov.au/articles/religious-affiliation-australia

[54] https://www.bbc.co.uk/ethics/euthanasia/religion/religion.shtml

[55] Paul Santamaria KC, "UK VAD Bill, As Bad As It Is, Is Still Better Than Ours," *News Weekly* No 3193, July 12. 2025, 14-15

[56] Paul Santamaria KC, "UK VAD Bill, As Bad As It Is, Is Still Better Than Ours," *News Weekly* No 3193, July 12. 2025, 14-15

palliative, medical and psychiatric care and access to medical specialists and to dignity therapy.

3. Consultation Topic 2: Delivering VAD in the NT

If VAD is to be introduced, in the NT, there would be benefits in adopting a single, centralised service for the delivery of VAD. This could assist to protect others – particularly medical practitioners and pharmacists from being tainted with association with VAD. Whilst it is important that experts identify the appropriate dosages of life ending pharmaceuticals applied or provided for VAD, to avoid patient suffering or delayed deaths, there are nonetheless good reasons for a class other than medical practitioners and pharmacists to be engaged in VAD. There are also risks with a centralised approach.

Why medical practitioners should not be involved in VA
Some have argued that only non-doctors should deliver euthanasia.[57] As noted above prevailing fears of the medical profession among some members of the NT's indigenous population may have been exacerbated by the introduction of the *ROTI Act.*

Risks with a centralised approach.
A centralised approach in itself may create issues of concern as advocates for VAD may be most attracted to take up those roles. The NT experience of the *ROTI Act* is illustrative here. In the brief period of operation of the *ROTI Act,* the euthanasia campaigner Dr Philip Nitschke administered euthanasia to all of those who accessed the procedure. He also paid for the fees of one of the psychiatrists who signed off on the availability of euthanasia for one of his patients.[58] It would be important to ensure that both the fact and perception of bias is avoided. If VAD practitioners, pharmacists and care negotiators consciously or unconsciously have a preference for VAD, this may result in an actual or, at least, perceived conflict of interest. Such a circumstance would also fail to ensure that throughout the process the full range of options available to patients are fully and dispassionately discussed to ensure that each person who undergoes VAD has really freely exercised and informed choice. For those involved in the proposed Care Navigator Service it will be critical that they objectively and without a pro-VAD bias are able to refer "people to other services and resources." They must also be trained in understanding and respecting religious and Aboriginal and Torres Strait Islander perspectives on VAD and not to see their role as promoting VAD exclusively or in a biased way.

Resourcing

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[57] Srinic," Arguments in Support and Against Euthanasia" 6; Somerville, *Bird on an Ethics Wire* 37,151 where Somerville argues that a specially trained group of lawyers rather than physicians ought be tasked with the role of administering euthanasia.

[58]Guy Barnett, Mary Jo Fisher and Russell Trood, "Statement of Liberal Senators" Standing Committee on Legal and Constitutional Affairs," Report of the Standing Committee on Legal and Constitutional Affairs Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008"68 [1.6]

As Table 1 in the Paper clearly demonstrates, if VAD were to be introduced in the NT, very substantial annual increases in the numbers of Territorians seeking to do so in this way should be anticipated as the practice becomes normalised and seen as an option.

Questions for consideration

If VAD is to be introduced, in the NT, there would be benefits and challenges in adopting a single, centralised service for the delivery of VAD. This could assist to protect others – particularly medical practitioners and pharmacists from being tainted with association with VAD.

A centralised approach in itself may create issues of concern as advocates for VAD may be most attracted to take up those roles. This may result in an actual or, at least, perceived conflict of interest. It may also fail to ensure that, throughout the process, the full range of options available to patients are fully and dispassionately discussed to ensure that each person who undergoes VAD has really exercised, informed, free choice. For those involved in the proposed Care Navigator Service it will be critical that they objectively and, without a pro-VAD bias, are able to refer "people to other services and resources." They must also be trained in understanding and respecting religious and Aboriginal and Torres Strait Islander perspective on VAD and not to see their role as promoting VAD exclusively or in a biased way.

Delivering VAD in remote communities

The Paper identifies very serious impediments to VAD being introduced in remote communities which it refers to as "barriers to accessing VAD." As the Paper notes, there is a disproportionate burden of disease in rural and remote areas of the NT and the NT Health Service faces geographical challenges. For VAD to really be a free choice these problems must first be solved – residents across the NT must have access to appropriate medical care, diagnosis of illness and disease by appropriately qualified specialists and access to high quality pain relief, dignity therapy and palliative care. Without those improvements people will die by VAD, not because they have a terminal illness and a short life expectancy accurately diagnosed, but due to the lack of appropriate care.

Telehealth

Telehealth may have some benefits in the provision of healthcare but VAD should not be characterised in that way. VAD is not healthcare. VAD does not lend itself to remote consultations. As Santamaria has observed:

> How a medical practitioner could safely conclude by a telephone call or a Zoom meeting that there is no evidence or suspicion of pressure from family members upon that patient is beyond me, particularly where the patient's own GP need not be involved. A kid taking orders in a Macca's drive through has a more meaningful opportunity if observing that things don't look right. [59]

Equity of access principles

It is not sufficient for reviews to consider principles of the entitlement of all residents – metropolitan and regional – to high quality care including palliative care and treatment and I

[59] Paul Santamaria KC, "UK VAD Bill, As Bad As It Is, Is Still Better Than Ours," *News Weekly* No 3193, July 12. 2025, 14, 15

would add pain management and relief. It is also not just a matter of ensuring that everyone has the same access to care. If high quality access and information about the accessibility of specialists for accurate diagnosis and care, palliative care, pain relief and treatment for suicidal ideation, such as dignity therapy as discussed above, are not available to all, people will opt for VAD who are not really doing so due to free choice but due to inadequate access to treatment and options. VAD should not be a substitute for proper care and that must be in place first in the NT.

Regional access support services

Regional access to VAD access cannot be considered without first ensuring real access in regional areas to medical and mental health care including specialist diagnosis, current best practice pain relief and palliative care. The NT should not fund visiting VAD services without first ensuring these services are in place.

Questions for consideration

The first steps which need to be taken, if VAD is to be introduced, and the intention is that people in remote and regional communities can access VAD fairly and safely is first to ensure real access in remote and regional areas to adequate medical and mental health care including specialist diagnosis, current best practice pain relief and palliative care. The NT should not fund visiting VAD services or introduce VAD without first ensuring these services are in place. To do so would be to introduce VAD services which do not meet the Paper's definition of VAD in the Introduction. People who are experiencing pain or mental health issues or who have been misdiagnosed or who are not being provided with access to medical care and palliative care may not be freely choosing VAD either because they are not competent to do so or they have been misinformed about their medical condition, their options, their likely life expectancy etc. Introducing VAD first will inevitably results in VAD deaths occurring in fact because of a failure to adequately provide other services.

Aboriginal and Torres Strait Islander cultural safety

Many indigenous organisations have expressed concerns about the impact of VAD on Aboriginal health.[60] Indigenous concerns about the *ROTI Act* were also aroused by its contradiction of indigenous cultural law and this concern was expressed in a "Letter Strick" delivered to the Commonwealth Parliament by the Yolnu Nation/States within East Arnhem land.[61] There is anecdotal evidence of fear of euthanasia causing indigenous patients to leave hospital and refuse immunisations during the operation of the *ROTI Act*.[62] Any introduction of VAD in the NT would require respect for cultural differences which should not simply be classified as "challenges." If patients who are unwell or their communities are concerned that their treating doctors are advocates for VAD, this is not an irrational

[60] Standing Committee on Legal and Constitutional Affairs," Report of the Standing Committee on Legal and Constitutional Affairs Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008" (June 2008) 35 [4.1.2],52-53 [4.74]-[4.77].

[61] Quirk, "Euthanasia in the Commonwealth of Australia" 425 fn22

[62] Standing Committee on Legal and Constitutional Affairs," Report of the Standing Committee on Legal and Constitutional Affairs Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008" 58 [4.98]. Note however that a report prepared in 1997 indicated that there was no evidence from patient travel data or hospital separations the *ROTI Act* affected the willingness of Indigenous Australians to attend hospitals for treatment: Standing Committee on Legal and Constitutional Affairs," Report of the Standing Committee on Legal and Constitutional Affairs Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008" 59 [4.103]

concern. Different understandings of illness and death require respect and understanding. As the Paper notes, family and kinship are particularly important in many Aboriginal and Torres Strait Island cultures. The fact that Western society might have moved towards a great emphasis on the individual and on personal autonomy and individual decision making does not mean that a more communitarian approach is wrong or a "challenge." The fact is that, the death of a person has impacts beyond the individual – it impacts family, friends and the community. Whilst a legitimate concern for those designing VAD legislation is to protect individuals from family members who, for ulterior purposes (such as potential inheritance), might seek to persuade or pressure individuals to opt for VAD, family members (and in some cultures this may extend to community beyond immediate or blood family) do have a legitimate and important role to play in any consideration by an individual to choose VAD. Individuals who are terminally ill may form views about their own worth and value which are not those of their family and community.

The Aboriginal and Torres Strait Islander communities are not the only communities with views about VAD which require respect and understanding. In the last census, the NT was one of the most religious places in the country having the second lowest number of respondents to identified No Religion as their religious affiliation.[63] In Australia there is an "astonishing level of religious ignorance and oblivion,"[64] as Christian Brugger has observed. Many medical professionals and among the broader community share in this ignorance and oblivion. Most religions prohibit or disapprove of euthanasia. [65] The religious views of patients need to be understood and respected.

It is legitimate for individuals, families and kinship groups to reject VAD.

Guidance for Aboriginal and Torres Strait Islander people

Information providing guidance to Aboriginal and Torres Strait Islander people should not be limited to information about VAD or options for assistance to returning to Country (if this can in fact be provided safely to them and others) but include information about access to specialists for appropriate advice, medical and palliative care options etc.

Questions for consideration

Information providing guidance to Aboriginal and Torres Strait Islander people should not be limited to information about VAD or options for assistance to returning to Country (if this can in fact be provided safely to others) but include information about access to specialists for appropriate advice, medical and palliative care options etc. Any introduction of VAD in the NT would require respect for cultural differences which should not simply be classified as "challenges." A more communitarian approach respecting family and kinship is not wrong or a properly characterised as a "challenge." The fact is that, the death of a person has impacts beyond the individual – it impacts family, friends and the community.

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[63] Australian Bureau of Statistics, "Religious affiliation in Australia" 4 July 2022 https://www.abs.gov.au/articles/religious-affiliation-australia

[64] Quoted in Eddie O'Neil, "Lifting up the faith downunder" *National Catholic Register* (29 July 2017) https://www.ncregister.com/features/lifting-up-the-faith-down-under

[65] https://www.bbc.co.uk/ethics/euthanasia/religion/religion.shtml

4. Consultation Topic 3: Eligibility

Minimum age

Making a decision to access VAD is, of course, a decision of great importance – death is irrevocable. If VAD is introduced in the NT the fact that "research suggests that our brains are continually developing until our mid-to-late 20s"[66] would ground an argument for access to VAD to be limited to those in their mid-20's. Given that Australian society currently considers an 18 year old as an adult for voting and other matters this would be an appropriate minimum age.

Question for consideration

If VAD is introduced in the NT 18 would be an appropriate minimum age.

Residency

The NT should not facilitate forum shopping or "VAD tourism." If VAD is introduced in the NT, residency in the NT for 12 months prior to seeking access to VAD should be required or proof that the patient has lived for a substantial period of their life in the NT.

Question for consideration

The NT should not facilitate forum shopping or "VAD tourism." If VAD is introduced in the NT residency in the NT for 12 months prior to seeking access to VAD should be required or proof that the patient has lived for a substantial period of their life in the NT.

Eligible condition

Questions for consideration

The longer the period of prognosis the greater the risk of error. A 6 month or shorter period of prognosis until expected death from physical illness from a terminal illness should be required. Patients must have real access to best practice pain relief so that their decision making is not impaired and that they do not opt for VAD in circumstances where the cause is poor treatment.

Decision-Making capacity

Questions for consideration

The longer the period of prognosis the greater the risk of error and the greater potential for medical progress. There should not be special rules to facilitate access to VAD for those living with progressive illnesses.

Protections for those seeking VAD need to include assessment of their mental health with a determination by a psychiatrist – in consultation with the patient's GP and with

[66] The Attachment Project, Emotional Maturity: What It Is and How to Become More Emotionally Mature https://www.attachmentproject.com/psychology/emotional-maturity/

access to their medical history - that they are not suffering from treatable depression or another medical heath condition.

Any introduction of VAD in the NT would require respect for cultural differences. A more communitarian approach respecting family and kinship would be a worthwhile inclusion for all Territorians.

5. Consultation Topic 4: VAD Process

The Paper, particularly in this section, identifies a number of deficiencies with the numbers of medical personnel and health services in the NT including:

- “the shortage of suitably qualified nurse practitioners”

-“there are major resourcing gaps in many health specialties across the NT.”

The shortage of qualified and available pharmacist is also noted in the later section on **Supply, Storage and disposal of a VAD substance**.

Whist the Paper refers to the 2024 Expert Panel Report’s view, that the shortage of medical practitioners with relevant expertise and experience “could lead to a significant barrier to access VAD” and so proposed alternative approaches, to those of SA and Victoria, rather than “barriers to access” these are indicators that health care in the NT is not currently adequate. This needs to be addressed before VAD might be introduced otherwise persons will access VAD who are not making a fully informed free choice or who do not really meet the criteria for access. To minimise the risk of misdiagnosis, leading to a request for VAD, all patients must have access to specialist diagnosis by at least two specialists expert in the particular condition affecting the patient as well as specialists who are able to assess their medical health and to provide them with pain relief and palliative care options. As Santamaria has observed, unless those involved in assessing and coordinating VAD – and I would include in this those making assessments of mental health and capacity - actually know the patient there is real risk to the patient which the UK VAD Bill seeks to ameliorate by ensuring that the patient’s GP is informed. As he notes:

> There is no requirement in the UK or Australia that the person’s own GP participate in the eligibility process, but at least in the UK the person’s own GP is necessarily made aware that the patient, or the patient’s family members, have started along this path. In Australia, members of the patient’s family members may invite a practitioners who may never have set eyes on the patient before to become the coordinating doctor and who will be responsible for deciding whether the patient has been subjected to any form of coercion or undue influence by his or her family. Unlike the patient’s own GP, the introduced coordinating doctor will have no previous opportunity to know the illnesses, personality, hopes, expectation and fears of the patient: nor will that doctor have any knowledge or insight of the family dynamics at play. [67]

[67] Paul Santamaria KC, “UK VAD Bill, As Bad As It Is, Is Still Better Than Ours,” *News Weekly* No 3193, July 12. 2025, 14

The informing of the patient's GP will, of course, assist only where patients have a GP who knows them which is not universally the case in the NT. Those wishing to legislate VAD in the NT need to consider how to made the safeguards and protections for patients real – to protect those patients experiencing unaddressed pain (capable of being addressed), depression and mental health issues or who are at risk of coercion. Access to all medical records but also an ability to speak to those who know the patient may assist.

Requests

The NT should not adopt lesser standards of protection from coercion that other States.

Permits

It is important that, if VAD is introduced in the NT, patients are protected and that their decisions are fully informed and the process is transparent. Multiple and external decision makers – in advance - can form important safeguards.

Initiating a discussion about VAD

Medical practitioners can have a very strong influence on patients. They should not initiate discussion about VAD. Subject to respecting the religious and conscience rights of health professionals (discussed below) if a patient raises VAD, a health professional might discuss the relevant law so long as they did so whilst discussing pain relief and other treatment options including palliative care.

Health professionals who do not want to help with VAD

Conscientious Objection

Conscientious objection – and freedom of religion – are important human rights which are recognised in Australian domestic law and attract international protection. Whilst freedom of conscience and conscientious objection are not subsumed by freedom of religion, Australian Courts have made numerous statements recognising the importance of religious freedom in particular. It has been described as "the paradigm freedom of conscience,"[68] "the essence of a free society,"[69] "a fundamental concern to the people of Australia,"[70] "a fundamental freedom"[71] and as "a fundamental right because our society tolerates pluralism and diversity and because of the value of religion to a person whose faith is a central tenet of their identity."[72] Australian Courts have recognised "the importance of the freedom of people to adhere to the religion of their choice and the beliefs of their choice and to manifest their religion or beliefs in worship, observance, practice and teaching."[73]

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[68] *Church of the New Faith v Commissioner of Pay-Roll Tax (Vict)* 154 CLR 120 [1982-1983] 130 per Mason ACJ and Brennan J and *Aboriginal Legal Rights Movement Inc v State of South Australia and Iris Eliza Stevens* (1995) 64 SASR 551, 557

[69] *Church of the New Faith v Commissioner of Pay-Roll Tax (Vict)* 154 CLR 120 [1982-1983] 150 per Murphy J

[70] *Canterbury Municipal Council v Moslem Alawy Society Ltd* (1985) 1 NSWLR 525, 543

[71] *Aboriginal Legal Rights Movement Inc v State of South Australia and Iris Eliza Stevens* (1995) 64 SASR 551, 552 and 555

[72] *Christian Youth Camps Ltd v Cobaw Community Health Services Limited* [2014]] VSCA 75 [560] per Redlich JA.

[73] *Evans v New South Wales* 168 FCR 576 [2008], 580

The inclusion of a religious freedom provision in the *Australian Constitution* itself demonstrates that this freedom was considered one of particular moment in Australia at Federation. Whilst the *Australian Constitution* gives the Commonwealth powers in "what may be broadly described as public economic or financial subjects" [74] and protects or confers very few rights on individuals, s116 contains a proscription on the Commonwealth establishing a State religion or imposing any religious test for the holding of any Commonwealth office. It also prevents the Commonwealth from prohibiting the free exercise of religion.[75]

Freedom of conscience and religious belief is an important principle both in Australian and international law. Australia is party to a number of international agreements which recognise the right to freedom of religion. For example, Article 18 of the 1948 *Universal Declaration of Human Rights* provides that:

> Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.

Article 18(1)-(3) of the *International Covenant on Civil and Political Rights* (ICCPR), which Australia has been a party to since 1980, provides that:

> 1.Everyone shall have the right to freedom of thought, conscience and religion. This right shall include freedom to have or to adopt a religion or belief of his choice, and freedom, either individually or in community with others and in public or private to manifest his religion or beliefs in worship, observance, practice and teaching.
>
> 2. No one shall be subject to coercion which would impair his freedom to have or to adopt a religion or belief of his choice.
>
> 3. Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and **are necessary** to protect public safety, order, health, or morals or the fundamental rights and freedoms of others.

The United Nations Human Rights Committee, established under Article 29 of the ICCPR, has recognised that:

> The freedom to manifest religion or belief may be exercised "either individually or in community with others and in public or private". The freedom to manifest religion or belief in worship, observance, practice and teaching encompasses a broad range of acts …[76]

Under Article 2 of the ICCPR, Australia undertook to respect and ensure that everyone within Australia and subject to Australian jurisdiction, recognises the rights in the ICCPR. Article 9 of the *European Convention on Human Rights* (ECHR), which recognises the right to freedom of thought, conscience and religion, is in substantially the same terms as Article 18(1) of the ICCPR. As a matter of international law freedom of thought, conscience and

[74] *Russell v Russell* [1976] 134 CLR 495, 546 (*Russell v Russell*).

[75] Section 116 of the *Australian Constitution* provides that "The Commonwealth shall not make any law for establishing any religion, or for imposing any religious observance, or for prohibiting the free exercise of any religion, and no religious test shall be required as a qualification for any office or public trust under the Commonwealth."

[76] General comment no 22 [4])

belief should be interfered with only where necessary for the limited purposes set out in Article 18(3) of the ICCPR.

The European Court of Human Rights (ECHR) has observed that the maintenance of pluralism is dependent on maintaining freedom of religion.[77] Whilst Australian Commonwealth law has not domesticated the obligations of Article 18 of the ICCPR and the HR Act enacts a different standard to Article 18(3) there are some good Australian examples of the accommodation of conscientious objection, religious freedom and belief. [78]

Voluntary assisted dying and conscientious objection

Some religious tradition proscribe euthanasia and suicide and co-operation in either action. This is so, for example, in the Catholic religious tradition as the official teachings of that Church as contained in the Catechism of that Church explains:

> **Euthanasia**
>
> **2276** Those whose lives are diminished or weakened deserve special respect. Sick or handicapped persons should be helped to lead lives as normal as possible.
> **2277** Whatever its motives and means, direct euthanasia consists in putting an end to the lives of handicapped, sick, or dying persons. It is morally unacceptable. Thus an act or omission which, of itself or by intention, causes death in order to eliminate suffering constitutes a murder gravely contrary to the dignity of the human person and to the respect due to the living God, his Creator. The error of judgment into which one can fall in good faith does not change the nature of this murderous act, which must always be forbidden and excluded.
>
> **2278** Discontinuing medical procedures that are burdensome, dangerous, extraordinary, or disproportionate to the expected outcome can be legitimate; it is the refusal of "over-zealous" treatment. Here one does not will to cause death; one's inability to impede it is merely accepted. The decisions should be made by the patient if he is competent and able or, if not, by those legally entitled to act for the patient, whose reasonable will and legitimate interests must always be respected.
>
> **2279** Even if death is thought imminent, the ordinary care owed to a sick person cannot be legitimately interrupted. The use of painkillers to alleviate the sufferings of the dying, even at the risk of shortening their days, can be morally in conformity with human dignity if death is not willed as

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[77] *Case of Eweida And Ors v The United Kingdom* ECHR 48428/10,59842/10,51671/10 and 36516/10 15 January 2013 (*Eweida*) 30 [79]

[78] For example, although voting is compulsory in Australia if an elector has a religious belief that it is his or her religious duty to abstain from voting this will constitute a reasonable excuse under s 245(14) of the *Electoral Act* and s 45(13A) of the *Referendum Act see* Australian Electoral Commission, *Electoral Backgrounder: Compulsory voting* [41] *available at* http://www.aec.gov.au/About_AEC/Publications/backgrounders/compulsory-voting.htm. Exemptions are provided to religious bodies from a range of discrimination provisions to enable them to operate schools and to comply with their own doctrines in managing their own operations (e.g. *Sex Discrimination Act, 1984* (Cth) ss 5, 5A,14,21(3),23(3)(b), 37(1)(a),37(1)(d),37(2) and 38, *Age Discrimination Act 2004* (Cth) s35, the *Anti-Discrimination Act, 1977* (NSW) ss 8, 38S(2)(c), 49ZT(2)(c), 49ZXB(2)(c),49ZYB,49Y and 56()) and the *Equal Opportunity Act, 2010* (Vic) ss 83(1)-(2). For a summary of the exemptions from various discrimination provisions which are afforded to religious (and other) schools in Australia see Greg Walsh*, Religious Schools And Discrimination Law* (Central Press,2015) 1-11.

either an end or a means, but only foreseen and tolerated as inevitable Palliative care is a special form of disinterested charity. As such it should be encouraged.[79]

Suicide

2280 Everyone is responsible for his life before God who has given it to him. It is God who remains the sovereign Master of life. We are obliged to accept life gratefully and preserve it for his honor and the salvation of our souls. We are stewards, not owners, of the life God has entrusted to us. It is not ours to dispose of.

2281 Suicide contradicts the natural inclination of the human being to preserve and perpetuate his life. It is gravely contrary to the just love of self. It likewise offends love of neighbor because it unjustly breaks the ties of solidarity with family, nation, and other human societies to which we continue to have obligations. Suicide is contrary to love for the living God.

2282 If suicide is committed with the intention of setting an example, especially to the young, it also takes on the gravity of scandal. Voluntary co-operation in suicide is contrary to the moral law. Grave psychological disturbances, anguish, or grave fear of hardship, suffering, or torture can diminish the responsibility of the one committing suicide.

2283 We should not despair of the eternal salvation of persons who have taken their own lives. By ways known to him alone, God can provide the opportunity for salutary repentance. The Church prays for persons who have taken their own lives.

As a consequence, VAD creates serious issues for some religious believers and others who have a conscientious objection to the practice. For Catholics, seeking to live in accordance with the teachings of their Church, facilitating or participating in VAD – such as by informing patients who seek VAD of VAD services – is a very serious sin. As the Catechism observes:

1868 ….we have a responsibility for the sins committed by others when we cooperate in them:

- By participating directly or voluntarily in them;
- By ordering, advising., praising or approving them,
- By not disclosing or hindering them when we have an obligation to do so;
- By protecting evil doers.

In some religious traditions participation in such actions could be immoral not only in its own right but also because of the risk of scandal. This could be so in the Catholic religious tradition for example:

2284 Scandal is an attitude or behavior which leads another to do evil.
The person who gives scandal becomes his neighbor's tempter. He damages virtue and integrity;
he may even draw his brother into spiritual death. Scandal is a grave offense if
by deed or omission another is deliberately led into a grave offense.

2285 Scandal takes on a particular gravity by reason of the authority of those who cause it or
the weakness of those who are scandalized. It prompted our Lord to utter this curse:
"Whoever causes one of these little ones who believe in me to sin, it would be better for him to have
a great millstone fastened round his neck and to be drowned in the depth of
the sea."[85] Scandal is grave when given by those who
by nature or office are obliged to teach and educate others. Jesus reproaches the scribes and
Pharisees on this account: he likens them to wolves in sheep's clothing.

[79] *Catechism of the Catholic Church* https://www.vatican.va/archive/ccc_css/archive/catechism/p3s2c2a5.htm

> 2286 Scandal can be provoked by laws or institutions, by fashion or opinion. Therefore, they are guilty of scandal who establish laws or social structures leading to the decline of morals and the corruption of religious practice, or to "social conditions that, intentionally or not, make Christian conduct and obedience to the Commandments difficult and practically impossible." This is also true of business leaders who make rules encouraging fraud, teachers who provoke their children to anger,[88] or manipulators of pub lic opinion who turn it away from moral values.
>
> 2287 Anyone who uses the power at his disposal in such a way that it leads others to do wrong becomes guilty of scandal and responsible for the evil that he has directly or indirectly encouraged. "Temptations to sin are sure to come; but woe to him by whom they come!" [80]

As the Australian Bahai Community noted in their Submission to Australian Human Rights Commission, *Inquiry Into Freedom of religion and Belief in 21st Century Australia* in 2011 "[T]here is a tendency to treat the right to freedom of religion or belief as less important than certain other civil and political rights and this right is often treated as a 'second class citizen' in the sphere of human rights.'[81] As Laycock and Berg have observed:

> [C]ommitted religious believers argue that some aspects of human identity are so fundamental that they should be left to each individual, free of all nonessential regulation, even when manifested in conduct. For religious believers, the conduct at issue is to live and act consistently with the demands of the Being that they believe made us all and holds the whole world together.[82]
>
> No religious believer can change his understanding of divine command by any act of will…Religious beliefs can change over time…But these things do not change because government says they must, or because the individual decides they should … [T]he religious believer cannot change God's mind.[83]

Since religious belief is such an integral part of a person, a religious person can only flourish when they are freely able to worship and live their faith. As Anthony Lester has observed:

> Reconciling equality and religious freedom is particularly difficult. In a plural democratic society, cultural differences should be accorded equality for respect unless they are abusive or repressive. What to one group is praiseworthy to another group may seem anti-social; for example, wearing a niqab from head to toe.[84]

As I have previously observed:

> Australia is a pluralist, multi-faith, multi-racial society. The religious landscape of Australia is a constantly evolving one, but Australia has deep historical Christian roots. From the first census in 1911, "the majority of Australians have reported an affiliation with a Christian religion." Even though this affiliation has been declining "from 96% in 1911 to 61% in 2011," the Christian faith traditions continue to dominate in Australia, with Catholicism being the largest

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[80] *Catechism of the Catholic Church* https://www.vatican.va/archive/ccc_css/archive/catechism/p3s2c2a5.htm
[81] Submission No 1921
[82] Douglas Laycock and Thomas Berg, S*ame-Sex Marriage and Religious Liberty* 99 VIR. L.REV 1.[2013], 3
[83] Ibid 4.
[84] Anthony Lester*, Five Ideas To Fight For* (OneWorld, 2016) 56.

> Although statistics showing the religious affiliation of health practitioners in Australia are not available, if the percentage of Catholic health practitioners replicates the general trend indicated by the census data, about one-quarter of health practitioners in Australia have an affiliation to Catholicism. The European Court of Human Rights (the "ECHR") has observed that maintaining pluralism is dependent on maintaining freedom of religion.[85]

Medical practitioners especially require protection of their religion, conscience and belief because their occupation requires them to give advice to their patients about what procedures are most appropriate for them and that necessitates them expressing their honest beliefs and opinions. The NT should avoid creating a circumstance in which medical advisers, who have a conscientious or religious objection to VAD, are forced to inform patients of VAD services. This could be detrimental to their mental health because medical practitioners who act against their conscience can experience moral distress. As I have previously observed:

> Moral distress involves feelings of helplessness, anxiety, anger, guilt, sorrow, and frustration. It can have adverse effects on self respect, self-esteem, patient care and job satisfaction. It can cause burnout, and contribute to health practitioners leaving their vocation. Some studies indicate that moral distress is most likely to affect nurses (and one might extrapolate from these studies to apply to other health practitioners) whose ethical beliefs are most influenced by their religious faith. Health practitioners who consistently act against their conscience can also become desensitized to it. They are at greater risk of developing indifference to patients and "doubling" or "compartmentalization," leading to a weakened ability to make the types of ethical decisions critical for health practitioners.[86]

If the State requires medical practitioners to against their conscience – or to falsify causes of death on death certificates - it is setting up a regime which undermines their ability to make ethical choices and give ethical advice. I have written elsewhere about the risks of mandating participation by health professionals in such activities:

> This would be a particular concern if conscientious objection were not to be respected and medical practitioner participation by prescribing or administering a lethal injections or providing a referral to someone who would be willing to do so. There is growing evidence that requiring health practitioners to act against their conscience can lead to physical and mental symptoms known as 'moral distress' and to desensitising of conscience. This particularly affects health practitioners who consistently act against their conscience. These practitioners are left at greater risk of developing indifference to patients and "doubling" or "compartmentalization" which leads to a weakened ability to make the types of ethical decisions critical for health practitioners.[87]

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[85] Michael Quinlan, "When the State Requires Doctors to Act Against their Conscience: The Religious Freedom Implications of the Referral and the Direction Obligations of Health Practitioners in Victoria and New South Wales", 2016 BYU L. Rev. 1237 (2017) 1254-1255.

[86] Michael Quinlan, "When the State Requires Doctors to Act Against their Conscience: The Religious Freedom Implications of the Referral and the Direction Obligations of Health Practitioners in Victoria and New South Wales", 2016 BYU L. Rev. 1237 (2017) 1270-1271. Available at: https://digitalcommons.law.byu.edu/lawreview/vol2016/iss4/7118.

[87] Quinlan, Michael (2016) ""Such is Life": Euthanasia and capital punishment in Australia: consistency or contradiction?," *Solidarity: The Journal of Catholic Social Thought and Secular Ethics*: Vol. 6 : Iss. 1 , Article 6, 22

For these reasons, if VAD is to be re-introduced into the NT, the rights of registered health – professionals – and others - to freedom of conscience and belief require protection. In particular, a registered health practitioner who has a conscientious objection to VAD should have the right to refuse to:

• provide information about voluntary assisted dying;
• participate in the request and assessment process;
• apply for a VAD permit;
• prescribe, supply or administer a VAD substance;
• be present at the time of the administration of a VAD substance;
• dispense a prescription for a VAD substance.
• attend training or establish competence in providing information about VAD, participating in the request and assessment process, applying for a VAD permit, prescribing, supplying, dispensing or administering a VAD or in relation to any conduct relevant o being present at the time of administration of a VAD substance.

International law also provides for the protection of an individual's privacy. ICCPR Article 17 provides that:

> No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation. (Art 17.1)

General Comment 22 clarifies the interaction of Articles 17 and 18 of the ICCPR as follows:

> In accordance with articles 18.2 and 17, no one can be compelled to reveal his thoughts or adherence to a religion or belief. (para 3)

Imposing an obligation on registered health professional to inform requesting patients of VAD services is inappropriate. It imposes an obligation which some registered health professionals will consider to be participation in an immoral act. Obligations to refer of this kind seriously undermine freedom of conscience and belief and elevate the legislative objective of proving VAD over the protection of that fundamental human right. It is an example of the "tendency to treat the right to freedom of religion or belief as less important" and as "a 'second class citizen' in the sphere of human rights.'[88]

Conscientious objection at residential aged-care facilities

Residential aged-care facilities, which are part of a religious tradition, should not be forced to provide VAD services or to permit VAD to occur on their premises. Australian law and international human rights law recognise that freedom of religion is not limited to individuals. In manifesting their religious beliefs, religious believers in some religious traditions, have established entities which carry out works such as education, the provision of charity, the provision of food or housing to the underprivileged, the provision of palliative or aged care or hospitals. These entities founded by religious believers are a communal demonstration of religious faith and service and a manifestation of that faith in their own right. They are also seen by others as representative of a religious faith. The religious objects or mission of an entity may preclude that organisation from enabling acts contrary

[88] Submission No 1921

to the teachings of that faith to be performed on premises owned or operated by that entity. The institutional beliefs or such entities warrant protection. In *Sindicatul "Pastorul Cel Bun" v Romania* (2014) 58 EHHR 10 the Grand Chamber of the European Court of Human Rights stated that:

> [136] The autonomous existence of religious communities is indispensable for pluralism in a democratic society and is an issue at the very heart of the protection which Article 9 affords. It directly concerns not only the organisation of these communities as such but also the effective enjoyment of the right to freedom of religion by all their active members. **Were the organisational life of the community not protected by Article 9, all other aspects of the individual's freedom of religion would become vulnerable**[89] **[emphasis added]**

The nature of the right to freedom of religion in Australia, was considered by Kenny, Greenwood and Logan JJ of the Federal Court of Australia in *Iliafi.* The Court there noted:

> The right to freedom of religion is a complex right regarding religious beliefs and practices of worship. In *Metropolitan Church of Bessarabia v Moldova* (2002) 35 EHHR 13 (*Church of Bessarabia*), the European Court of Human Rights described religious freedom in the following way (at [114] and [117]):
>
>> **[114] While religious freedom is primarily a matter of individual conscience, it also implies, inter alia, freedom to "manifest [one's] religion" alone and in private or in community with others, in public and within the circle of those whose faith one shares. *Bearing witness in words and deeds is bound up with the existence of religious convictions.* That freedom entails, inter alia, freedom to hold or not to hold religious beliefs and to practice or not to practice a religion** … Article 9 lists a number of forms which manifestation of one's religion or belief may take, namely worship, teaching, practice and observance. Nevertheless, Article 9 does not protect every act motivated or inspired by a religion or belief …
>>
>> [117] [I]n principle the right to freedom of religion for the purposes of the Convention excludes assessment by the State of the legitimacy of religious beliefs *or the ways in which those beliefs are expressed.* [Citations omitted; emphasis added.] [90]

As the Court in *Iliafi* further noted:

> In *Church of Bessarabia*at [118], the European Court expressly linked individual religious freedom to the protection of the autonomy of the collective church, stating that:
>
>> [118] [S]ince religious communities traditionally exist in the form of organised structures, Article 9 must be interpreted in the light of Article 11 of the Convention, which safeguards associative life against unjustified State interference … **Indeed the autonomous existence of religious communities is indispensable for pluralism in a democratic society and is thus an issue at the very heart of the protection which Articles 9 affords …** [Citation omitted; emphasis added.]
>
> The European Court of Human Rights has repeatedly affirmed this statement: see, for example, [78] below; see also J Rivers, "Religious Liberty as a Collective Right" (2001) 4 *Law and Religion: Current Legal Issues* 227.

Aged and health care facilities should be permitted not just to refuse to provide VAD services but also to refuse to permit VAD to be provided on premises or to otherwise

[89] *Sindicatul "Pastorul Cel Bun" v Romania* (2014) 58 EHHR 10 [136] as quoted in *Iliafi v Church of Jesus Christ Of Latter Day Saints Australia* (2014**)** 311 ALR 354 (*Iliafi*) [77]
[90] *Iliafi* [74]

participate in VAD in any way due to an ‘institutional conscientious objection.” It is an appropriate recognition of the importance of religious organisations. They are a key aspect of the respect for diversity and difference in Australia and a visible demonstration of pluralism. It would be reasonable to require such institutions to inform the public of their position. Providing or facilitating VAD, should it become law in the NT, should not be a practice in which entities with a religious mission or foundation which consider such activities to be immoral, are obliged to participate.

All medical facilities and medical practitioners should also not be required against their conscience or religious beliefs to provide VAD or to participate in the procedure by being required to provide referrals or to inform patients of VAD services because mandating such conduct would be a positive discouragement for people with a religious or conscientious conviction against assisting patients to die from becoming medical practitioners. It would also be a positive discouragement to hospitals, aged care facilities and hospices operated by religious organisations which consider assisted dying to be immoral, from beginning or continuing to provide those services. Given the number of organisations of this kind operated by the Catholic Church, for example, the withdrawal of the operations of those providers would be deeply problematic for the State and for patients wishing to access other health services.

The opposition of many religious traditions to euthanasia and assisted suicide is well known but to avoid any uncertainty in the community – among medical providers, ambulance and emergency services and the general public – it would be appropriate for entities with an “institutional conscientious objection” to VAD to make that it clear by signage at their facilities, on their websites and in other promotional materials that they are unable to provide or participate in that activity including be permitting ti to occur on their premises. This will obviate the need for referral or transfer of patients in such facilities who wish to seek VAD and enable patients wishing to be treated in facilities which do not engage in VAD to be treated in a facility which shares their position.

In a multi-faith, plural society respect for difference and diversity ought be demonstrated by recognizing that individuals and entities are different and not all can or ought be obliged to participate in every practice which the State has determined to make lawful.

Questions for consideration

Health practitioners with a conscientious or religious objection to VAD should not be required to participate in any way with VAD including by providing information to a centralised VAD service.

All persons who may be part of VAD should have their freedom of conscience and religion protected not just registered health practitioners.

Health practitioners are entitled to privacy in relation to their beliefs. They should not be required to disclose their beliefs to persons interested in accessing VAD.

Health services which form part of a religious tradition which considers VAD to be immoral should not be required to permit VAD on its premises.

Administration of VAD substance

If VAD is legislated in the NT, particularly given the large proportion of the population who identify as Aboriginal or Torres Strait Islander, the belief that some members of this population might seek VAD on Country and given that this may be in a remote or regional community, creates very challenging and serious safety issues in relation to the storage of the VAD substances and the process of VAD itself. If self-administration is permitted in remote and regional areas there may, for example, be no health professional available to assist in the event that the VAD substance does not act as expected. This does happen. Two 1992 studies from the Netherlands, found that doctors working in nursing homes and general practitioners reported complications in 12% of euthanasia cases.[91]

Supply, storage and disposal of VAD substance

Ensuring the safety of the VAD substance particularly in remote and regional locations may be particularly challenging – and to such an extent that the aim of VAD on country is not safe for the community. The range of these issues needs careful consideration in advance of the introduction of VAD as they go to its practical viability in the NT.

Palliative care services

Adequate access to palliative care in the NT – and across the NT – should be a driving ambition for the NT particularly given the health profile of its population. The Paper notes that "[e]ach jurisdiction where VAD legislation has been introduced has also focused on the future planning and investment in their palliative care services." The NT should not follow the approach of Australia's other States and Territories in introducing VAD before first ensuring the adequacy of availability of palliative care. To do so is to introduce Assisted Dying which is not truly voluntary as member so the community faced with a terminal illness and a short diagnosis cannot choose to live to natural death with adequate palliative care. Palliative care needs to precede not follow VAD otherwise people will die before they can access it.

Questions of consideration

Health care professional should be required to provide information on the range of medical treatments for their condition (including referrals for second opinions on prognosis and diagnosis), pain relief options and palliative care if a person requests VAD.

More resources should be provided for community education on palliative care.

VAD should not be introduced before adequate palliative care is available across the NT .

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[91] Johanna H Greonewoud, Agnes Van Der Heide, Bregje D Onwuteaka-Philipsen, Dick L.Willems, Paul J Van Der Maas and Gerrit Van der Wal "Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in The Netherlands" 342 *The New England Journal of Medicine* 8, 551, 555-556 n 14,15. See also Michael Cook," A peek behind Belgium's euthanasia curtain" *Careful*, February 8, 2016 accessible at http://www.mercatornet.com/careful/view/a-peek-behind-belgiums-euthanasia-curtain/17572

All patients diagnosed with a terminal illness – and essentially those considering VAD – must have access to specialist palliative care and advice from a specialist in palliative care.

Notifying and registering a person's death

Trust in government is very important and it was adversely impacted by COVID. According to the Australian Bureau of Statistics, trust in government is "linked to political participation, social cohesion and collaboration in tackling societal challenges." [92]According to OECD reports in 2020 45% of people surveyed in Australia expressed confidence in the government and this had improved by 2022 to 50%. [93] This is still a very concerning statistic. Trust in the truth of official medical and government documents, such as death certificates, is important. The NT should avoid creating a circumstance in which the State or any medical advisers are forced to lie. A person who dies by VAD – unless there is some other intervening cause – dies as a result of ingesting or injection with a VAD substance and so dies from VAD not from any other cause notwithstanding that that person has been diagnosed with a terminal illness. The records and death certificate should record VAD as the cause of death where it is the cause.

Questions of consideration

VAD should be recorded as the cause of death on death certificates where the death is a result of VAD.

6. Consultation Topic 5: Oversight and Review

Review Board

The Review Board must be a true Review Board. It must not consist of propagandists, enthusiasts or supporters of VAD who view the requirements of the VAD regime not as safeguards or protections but as blockages, challenges and impediments to access to VAD. When reaching a view it must avoid conflicts of interest. The Review Board must, as the Paper suggests, "reflect the geographic and cultural diversity of the Territory." It should include mental health experts, palliative care specialists, pain management experts, lawyers and bioethicists. The Review Panel should be prospective and review and approve applications on every case. As death is irrevocable, it is too late for the Review Board to identify an error after a person has died by VAD where that death might have been avoided, by example, by ensuring specialist diagnoses of diagnosis prognosis, treatment, pain management and palliative care options.

Reviewing eligibility decisions

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[92] Australian Bureau of Statistics, "Trust in national government" https://www.abs.gov.au/statistics/measuring-what-matters/measuring-what-matters-themes-and-indicators/cohesive/trust-national-government

[93]As cited in Australian Bureau of Statistics, "Trust in national government" https://www.abs.gov.au/statistics/measuring-what-matters/measuring-what-matters-themes-and-indicators/cohesive/trust-national-government

Decisions which should be reviewable by the NCTCAT should include not only the reviewable decisions set out in the Paper to align with other Australian jurisdictions but also eligibility, that is, the accuracy of diagnosis and prognosis and the quality of information provided on pain relief, treatment and palliative care options. The right of review should not be limited to the person seeking VAD. As the Paper notes, family and kinship are particularly important in many Aboriginal and Torres Strait Island cultures. The fact that Western society might have moved towards a great emphasis on the individual and on personal autonomy and individual decision making does not mean that a more communitarian approach is wrong or a "challenge." The fact is that, the death of a person has impacts beyond the individual – it impacts family, friends and the community. Family members (and in some cultures this may extend to community beyond immediate or blood family) do have a legitimate and important role to play in any consideration by an individual to choose VAD and in the process. Every death of a person brings to an end that person's interactions with others, advice giving, storytelling and shared experiences. Individuals who are terminally ill may form views about their own worth and value which – unbeknown to them - differ from those of their family and community. If VAD is introduced in the NT it should provide notification requirements to the family or, at least, part of the process should involve consultation with the family (as understood in the relevant cultural group) so that they will, at least, be aware of the individual's VAD request and of the review process.

Questions for consideration

Decisions which should be reviewable by the NCTCAT should include not only the reviewable decisions set out in the Paper to align with other Australian jurisdictions but also eligibility itself, that is, the accuracy of diagnosis and prognosis and the quality of information provided on pain relief, treatment and palliative care options.
The timing that generally applies for appeal to NCTCAT of 28 days appears appropriate.
Family members and those other persons who have a sufficient and genuine interest in the rights and interests of the person seeking VAD.

Reviewing the operation of legislation

The NT is a unique place. Experience with the *ROTI Act* indicates that there were failings in its implementation and operation. A review after two years of commencement and then after every three years would be appropriate in the circumstances.

The review should consider the adequacy of palliative care and pain management in the NT as well as the compliance and operation of VAD.

Questions for consideration

A review after two years of commencement and then after every three years would be appropriate in the circumstances.

The review should consider the adequacy of palliative care and pain management in the NT as well as the compliance and operation of VAD.

Implementation timeframe

VAD should not become operational in the NT until 18 months after the adequacy of medical treatment including mental health care and access to dignity therapy for those seeking VAD, palliative care and pain management is in place.

Questions for consideration

VAD should not become operational in the NT until 18 months after the adequacy of medical treatment including mental health care and access to dignity therapy for those seeking VAD, palliative care and pain management is in place.

Conclusion

The NT has a different population mix and different health and logistical issues to the rest of Australia. It has a larger Aboriginal and Torres Strait Islander population and comparatively high levels of religiously. The NT is a special place. Like most of the world, the NTt presently does not permit euthanasia or VAD. There are real challenges in providing adequate medical care across the Territory. Addressing those concerns is essential before considering legislating VAD. To do so in advance of ensuring access to quality and best practice pain management, palliative care and treatment for suicidal ideation among the terminally ill in the form of dignity therapy would be to introduce assisted dying which not being truly free, real and informed choice would not be properly described as voluntary.

11 August 2025

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