Voluntary Assisted Dying in the Northern Territory Submission

To Whom It May Concern:

I write to provide my submission regarding the proposed Voluntary Assisted Dying (VAD) legislation for the Northern Territory. I would like to begin by thanking you for the thoroughness of your consultation process and the opportunity to contribute to this important discussion.

While I understand that both sides of this debate are motivated by compassion and genuine concern for vulnerable people, I respectfully request that you ensure any new laws are as conservative as possible to protect both human life and dignity. Even the most tightly restricted legislation carries significant risks, and good intentions alone are not sufficient safeguards.

Question 1: Do you support making VAD legal in the NT?

I strongly oppose the legalisation of VAD in the Northern Territory for several important reasons.

Life should be inherently valued, regardless of circumstances. As a society, we must demonstrate to our elderly and sick that they remain valued members of our community. The existence of VAD schemes can subconsciously send the message that these individuals have nothing to offer society, undermining their sense of worth and belonging.

The introduction of VAD represents a fundamental shift in how we view and value life, suggesting that life becomes disposable when it no longer meets certain criteria. This crosses a significant legal and ethical boundary that cannot easily be reversed. It's morally and ethically wrong - the health system should have no part in ending someone's life.

The concept of "quality of life" is entirely subjective - who has the authority to determine that one person's life is less valuable than another's? Even "intolerable suffering" is subjective and cannot provide an objective standard for such irreversible decisions. I'm concerned that we are focusing too much on quality of life when it's so subjective, and I worry about this becoming an option for someone who is simply 'tired of life'.

Evidence from other jurisdictions demonstrates that VAD laws inevitably expand over time. What begins as legislation for terminally ill adults eventually encompasses access for those with disabilities, mental health conditions, dementia, and even children. Belgium's 2014 decision to make children of any age eligible for euthanasia illustrates this concerning trend. As a parent, I find this abhorrent.

Elder abuse and inheritance impatience are rising concerns that these laws could exacerbate. In Oregon, 54% of people who accessed assisted suicide cited "being a burden on family, friends, or caregivers" as a reason - a percentage that has steadily increased over time. This suggests external pressure rather than truly autonomous choice.

Whether or not someone feels pressure to die is incredibly difficult to determine. Sometimes this is direct, but often it's indirect. For someone with disabilities, pressure can lead to concerns about the impact their life and care is having on others. When euthanasia is an option this can result in indirect pressure to make that choice. No safeguard has been able to protect against this.

I have serious concerns about the risk of elder abuse and want to see safeguards in place for this. Even for older people who are worried about the inconvenience on their families - my family cared for my grandmother in her final year and we wouldn't have traded that for anything. Given her

constant worry about inconveniencing people, I can't help but wonder if she had had the option, whether would she have considered terminating her own life.

Our NT health system already struggles to provide basic healthcare services, and I have experienced this firsthand. Implementing VAD would divert millions of dollars and valuable healthcare resources away from life-saving to life-ending care. Instead of introducing new ways to end life, we should focus on improving palliative care services.

When basic healthcare services are inadequate, people may be forced to choose VAD not out of genuine preference but due to lack of alternatives. This creates an *unacceptable* inequality where vulnerable Australians face different options based on their access to quality care.

Legislation is written for everyone - not just those privileged few in "best case" scenarios who are highly independent, educated, and unpressured. We must acknowledge that VAD advocates often come from positions of privilege with access to quality healthcare, supportive families, and financial resources. However, this legislation will disproportionately impact our most disadvantaged - those with messy families, inexperienced doctors, limited health literacy, financial hardship, and systemic marginalisation who already struggle to feel valued. For many vulnerable Australians, truly "free" choice is almost impossible. While the privileged may have genuine autonomy, for the disadvantaged VAD becomes another inequality where society's most vulnerable are subtly encouraged toward death whilst the privileged retain life-preserving care, creating a two-tiered system where socioeconomic status determines whether you are encouraged to live or die.

VAD should never be offered as a convenient solution or become part of the regular suite of management options provided to patients. The power imbalance between doctors and patients must be carefully considered - when a healthcare professional suggests VAD, the implicit authority of their position carries enormous weight. *Every* possible range of options ought to be considered first.

Rather than introducing VAD, we should focus resources on improving palliative care services. The fact that families advocate for VAD because they cannot access adequate support for their loved ones represents a systemic failure that should be addressed through better care, not assisted death. Shouldn't we be focusing on how to treat people and give better palliative care options first? The fact that families are advocating for this because they can't care for their loved ones and have no help is just devastating.

Aboriginal people may experience worse health outcomes due to increased fear of accessing health services if VAD exists. Given existing mistrust and misinformation about the hospital system in Indigenous communities, VAD could further discourage people from seeking necessary medical care.

As VAD becomes more socially acceptable, there is a risk that people choosing palliative care may be viewed as selfish. VAD must always remain a last resort, never a normalised option that creates pressure for vulnerable individuals. I am concerned that people might be viewed as selfish for wanting a palliative care route instead of VAD, as this becomes more societally acceptable.

While euthanasia and assisted suicide are generally proposed as a compassionate response to the end of life, we can forget that these proposals are also heard by many vulnerable people who hear that society agrees with their worst thought: their life might not be worth living after all.

The practice of euthanasia and assisted suicide tends to expand over time, and there is no reason to think we would be immune. Whatever the safeguards, legalising euthanasia and assisted suicide would divide society into two unequal groups - telling some people to hang on to life because their suicide would be a tragedy, while telling others that their suicide is understandable and rational.

In 2015 when Scotland considered assisted dying legislation, they found that "there are ways of responding to suffering (such as increased focus on palliative care and supporting those with disabilities) which do not raise the kind of concerns about crossing a legal and ethical 'Rubicon' that are raised by assisted suicide." They rejected assisted dying, and focused on improving their palliative care services instead.

While I recognise the compassionate intentions behind VAD proposals, the risks are simply too great. Even the most restricted legislation would result in wrongful deaths - people who are misdiagnosed, feel like a burden, or slip through safeguards. These deaths would be wrong even according to the bill's own criteria.

Question 2: What eligibility criteria should a person need to meet before they can access VAD?

If VAD were to proceed despite my opposition, the most restrictive criteria possible should include:

- At least 18 years old
- Mental competence to consent
- Terminal diagnosis with death expected within 6 months
- Experiencing intolerable suffering directly related to the terminal diagnosis
- Mandatory access to *adequate* palliative and aged care services for a specified minimum period
- Comprehensive mental health assessment to rule out depression or other conditions driving the wish to die
- Offer of support services and alternatives to VAD
- Family notification and consultation in all cases

However, I emphasise that even these criteria are problematic. Medical prognosis is more art than science - Oregon's data shows that some people prescribed lethal drugs lived longer than their six-month prognosis. Additionally, determining whether someone is free from pressure is extremely difficult and requires long-term doctor-patient relationships, yet Oregon's median relationship was only 10 weeks.

Question 3: How could the NT make sure that an eligible person can access VAD in a safe and effective way, including people living in remote areas, and Aboriginal and Torres Strait Islander people?

I believe that remote areas should be excluded entirely from VAD access. Lethal substances should not be permitted in remote communities where medical supervision and safeguards are inherently limited.

For Aboriginal and Torres Strait Islander communities, the focus should be on improving existing healthcare access and cultural competency rather than introducing VAD. Given the existing fear and mistrust of hospital systems, and concerns about communicating with people whose first language is not English, VAD poses unacceptable risks to these vulnerable populations.

The NT's previous experience with VAD in 1995 provides crucial evidence for these concerns. Consultation with Aboriginal people at that time revealed widespread concerns and opposition to VAD. Significantly, Aboriginal people were fearful, for themselves and their families, of seeking

health care for fear of 'being euthanised' without their consent. The majority of Aboriginal people viewed VAD as being abhorrent on moral and cultural grounds.

Current health disparities in the NT further highlight why VAD poses additional risks. Indigenous people represent 30% of the NT population but account for 46% of deaths and 68% of hospitalisations. Indigenous Australians in the NT have an avoidable death rate 4.2 times higher than non-Indigenous Australians. The NT health workforce needs to be increased by about 28% to reflect the population level of disease and injury, and approximately 25-30% of the total health disparity for the NT Indigenous population can be attributed to socioeconomic status.

Existing barriers to healthcare access for Aboriginal people in the NT would be exacerbated by VAD introduction, including lower access to employment, education and income in remote areas, financial hardship, and geographic isolation limiting access to specialist services.

Question 4: How could the NT monitor the process to ensure VAD is delivered safely and effectively?

The monitoring framework should incorporate more diverse perspectives, particularly including several members who hold reservations about VAD implementation. This is crucial because oversight committees can sometimes shift toward promoting broader access rather than maintaining strict oversight. It's essential that both faith-based communities and Indigenous groups have voices on these boards, especially given their cultural and spiritual objections to assisted dying practices.

I believe there needs to be a comprehensive digital tracking system for every VAD request to guarantee that mandatory waiting periods are actually being followed, not just documented after the fact. The public deserves transparency - all data, timelines, and any instances where the system has been misused should be publicly available for scrutiny.

In addition, healthcare workers must be protected from employment discrimination based on their moral or religious objections to participating in VAD. No one should be forced to choose between their conscience and their career.

However, I maintain that no safeguards can adequately protect against the fundamental risks inherent in VAD legislation.

In conclusion, I urge the panel to recommend that the Northern Territory take a similar approach to Scotland - investing in comprehensive palliative care, aged care services, and healthcare accessibility rather than introducing legislation that fundamentally changes how we value human life.

The vulnerable members of our society deserve our protection and support, not a form to sign when life becomes difficult. As legislators, you have a responsibility to stand alongside them in solidarity, assuring them that we deeply value their lives and want to help them through difficult times.

Thank you for your consideration of these concerns.

Yours faithfully

Sarah Doecke

NT [redacted]