From:	[redacted]
To:	LA VAD
Subject:	Submission regarding VAD. Michael Tong, [redacted]
Date:	Thursday, 28 August 2025 10:03:57 PM

CAUTION: This email originated from outside of the organisation. Do not click links or open attachments unless you recognise the sender and know the content is safe.

1. Do you support making VAD legal in the NT?

No.

I am a General Practitioner who has worked in the NT for over 10 years.

Many of us are familiar with the idea of "first, do no harm." However life is not always that simple, especially when there are cases of protracted suffering, and it may appear that the compassionate thing to do is to end a person's life. Indeed it may appear harmful to prolong a person's life. And here is where palliative care should play a greater role, assisting a person (passively) to die with dignity.

VAD breaches the core principles of medical ethics. Our goal as health professionals is to promote life, and restore normal functioning and prevent physical and mental harm. We are trained to look closely for signs of self harm and suicide risk, to raise the alarm and even call on authorities to prevent someone from self harming. VAD runs counter to this notion. Ironically, even on the Consultation Guide there is the phone number for Lifeline (presumably to help people avoid suicide), giving the impression that suicide is to be prevented, but VAD is acceptable. Thus VAD condones and sanitises suicide.

Critically, as opposed to suicide, VAD requires someone to actively assist in the death of a person. It is most likely to be a health professional, but I suppose that this could change in time. Regardless, with VAD, a doctor or trusted professional could change from supporting one's life, to supporting one's death. Patients deserve to be able to trust their health professionals to be consistent in their care. When patients are at their most vulnerable, this is ever more the case.

With VAD, not only are patients put in a difficult position as to whether they can fully trust their health professionals, but the health profession itself becomes conflicted. Those professionals who choose to partake in VAD must by necessity reframe their ethical and moral framework to accommodate it. Others will not be able to, and so there will be division. It is feasible to anticipate that eventually, to respect a patient's right, the right of a patient will be deemed more valued than the professional's right to refuse to partake (in a similar way to current abortion laws). There is an important need to safeguard conscientious objection, one of the hallmarks of our democratic, Western society.

With respect to the landscape of the Northern Territory, it is patently obvious that our local system is over stretched and at breaking point. The NT has the highest rates of many physical and mental health issues in Australia, and indeed the world. There is no capacity to introduce VAD with appropriate protocols to ensure it is delivered in the intended way given the current state of our health system. This is even more pronounced in the remote settings.

2. What eligibility criteria should a person need to meet before they can access VAD?
There is no eligibility criteria appropriate - greater effort should be put into palliative care.

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?

This is near impossible. Given that health care is currently difficult to deliver remotely due to language, culture, distance and lack of workforce, VAD, which is an aberration of usual health care, is highly likely to not be delivered as intended.

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

The only way this could be done would be for people to be euthanised under direct supervision. A register would need to be created including who is involved and where it occurs.

Dr Michael Tong