Life: the basic human right
RTLA
THE RIGHT TO LIFE AUSTRALIA INC.

Submission by The Right to Life Australia Inc.to the Legal and Constitutional Affairs Committee of the Northern Territory Legislative Assembly

15 August 2025

Whether the law should permit voluntary euthanasia or physician-assisted suicide is one of the most vital questions facing all modern societies.

Internationally, the main obstacle to legalisation has proved to be the objection that, even if they were morally acceptable in certain 'hard cases', voluntary euthanasia and physician-assisted suicide could not be effectively controlled; society would slide down a 'slippery slope' to the killing of patients who did not make a free and informed request, or for whom palliative care would have offered an alternative.

How cogent is this objection?

This submission will attempt to answer this question in the light to the current experience of voluntary euthanasia or physician-assisted suicide both in Australia and in other countries which have grappled with this issue.

What is The Right to Life Australia Inc

The Right to Life Australia Inc. (**RTLA**) is a non-religious, non-party political organisation, which has as its principal aim and objectives to ensure legal protection for the most vulnerable members of the Australian community. RTLA works to defend human life from its beginning to its natural end.

RTLA is truly a national organisation.

It has active members in all Australian states and territories.

Our advocacy and campaigns extend to all issues related, directly or indirectly, to the protection of human lives. In doing this, RTLA works with all organisations which share the same or similar aim and objectives.

Put simply, RTLA is a community based political pressure group.

With our RTLA members across Australia, we engage with governments at all levels in Australia, members of the parliaments of Australia, individual politicians, medical practitioners, health care professionals, health care providers including hospitals, lawyers, social workers and the education sector to name but some of the entities with which we engage.

Statement of opposition by RTLA to euthanasia and physician assisted suicide

RTLA states its unequivocal and complete opposition to all forms of euthanasia and physician assisted suicide.

The position of RTLA is that all human lives have intrinsic value and dignity regardless of their circumstances.

RTLA holds that it is the role of physicians, healthcare professionals, and all working in the health care sector to heal illness, alleviate suffering and to provide care and comfort to the sick and the dying.

This submission has been prepared and submitted in response to the request for submissions made by the NT Legal and Constitutional Affairs Committee of The NT Legislative Assembly considering legalising voluntary assisted dying (**VAD**) in the Northern Territory (**NT**).

Any bill which would legalise VAD would undermine the protection which our society is called to give to all citizens and in particular to our most vulnerable citizens

It is of great concern that legislators are seeking to incorporate this so called voluntary assisted dying (**VAD**) into palliative and medical care.

At first hearing, voluntary assisted dying sounds like a description of what should be occurring in normal medical practice: clinicians recognising those who are dying and then assisting them to live comfortably until they die.

Such medical practice is currently the domain of palliative care, which can, and does, deliver relief of pain and suffering to those who consent to receive it.

However, in the current inquiry into Voluntary Assisted Dying (**VAD**) in the NT, **VAD** means no less than the legalisation of euthanasia and physician assisted suicide: the exact opposites of palliative care.

As described, **VAD** is understood as a legalised medical process, through which patients may be prescribed lethal substances which they may take to cause their own deaths and be administered lethal substances by medical practitioners which will cause their deaths.

Physician assisted suicide (**PAS**) is when a physician helps a patient to kill themselves by prescribing a lethal drug to a patient for the patient to self-administer.

Euthanasia is when a physician directly administers a lethal drug to kill the patient.

Both physician assisted suicide and euthanasia are methods of intentionally killing human beings.

Despite physician assisted suicide and euthanasia both having being legalized in all Australia states and in some overseas countries, the legalizing of such practices can never be made safe. Both practices compromise the role of palliative care. They are both risks to patients with disabilities and undermine the care of the vulnerable.

An Important Observation on the Language used in the Short Consultation Guide: Parliamentary Inquiry into Voluntary

It is important to note the language used by the NT Legal and Constitutional Affairs Committee. The following is a quotation from the Committee's Short Consultation Guide:

> "The Parliament's Legal and Constitutional Affairs Committee has been asked to consult with the community on Voluntary Assisted Dying (**VAD**). The Committee has published a consultation paper which discusses the possibility of making **VAD** laws in the Northern Territory (NT)."

This short consultation guide then continues:

> "What is **VAD**?
>
> "**VAD** gives a terminally ill person the option to ask for medical help to end their life a time they decide. It is only available to people who meet several criteria, and it must be a voluntary and informed choice. Unlike the rest of Australia, VAD is not legal in the NT."

It is of concern that the Committee choses to only use the words, "Voluntary Assisted Dying" and the abbreviation "VAD" in its consideration of the deliberate ending of human life in a medical context..

The reality is that the Committee is inquiring into the whole matter of euthanasia and physician assisted suicide.

It is critical that in a discussion as important as this on the ending of a human life, that the language and terms used always be very precise and carefully defined.

Euthanasia, Voluntary Assisted Suicide (**VAS**)and Voluntary Assisted Dying (**VAD**) are not synonymous with **Physician-Assisted Suicide (PAS).**

Professor John Keown in his work, *Euthanasia, Ethics and Public Policy,* seeks to clarify some of the confusion and misunderstandings which have plagued the euthanasia debate as a result of the failure of proponents on both sides of the debate to define key terms and concepts.

In Australia, it is true that the phrase, **Voluntary Assisted Dying (VAD)** is widely used. However, the answer given above to the question, "What is VAD?" is far from an adequate definition of VAD.

So, what is Voluntary Assisted Dying?

Voluntary Assisted Dying means a person in the late stages of terminal disease can take a substance prescribed by a doctor which will bring about their death at a time they choose.

It is then obvious that what is covered by **VAD** in no way exhausts the way the lives of patients can be ended in a medical context.

The case for life ending treatment usually focuses on **Voluntary Active Euthanasia (VAE)**. Akin to this, there is another widely used phrase, **Physician Assisted Death (PAD)**, which is a euphemism for active euthanasia or direct killing of a patient by a medical practitioner.

Then we move onto the concept of **Physician Assisted Suicide** (**PAS**), in which the physician assists the patient to take his or her own life. It is worth noting that in the United States the focus has shifted more to **PAS** and away from **VAE**.

Highly relevant to the clarification of the terms used to describe how the lives of patients may be ended in a medical context of **voluntary assisted dying (VAD)** is the way in which carriage services could be used by health care professionals in their conduct of **VAD**.

The Australian Court Ruling against the use of carriage services in the context of voluntary assisted dying

The Howard government oversaw the passage of the Criminal Code Amendment (Suicide Related Material Offences) Act 2005, which was passed the Federal Parliament in June 2005. That Act made it a crime to use a telephone, fax, email or internet carriage service to discuss the practicalities of suicide-related material. The law prompted the Victorian Health Minister to recommend doctors discuss voluntary assisted dying exclusively in person with their patients, so they would not run foul of the federal law. Western Australia's assisted dying law explicitly states that voluntary assisted dying is not suicide.

The presence of the federal law and its relationship with state laws that created lawful assisted dying schemes resulted in a legal grey area over whether voluntary assisted dying, as authorised by a state/territory law, constitutes '**suicide**' within the meaning of the carriage service offences contained in the Commonwealth Criminal Code. In 2023 a Melbourne GP pursued legal action in the Federal Court to clarify the definition of suicide in the federal criminal code and its applicability to state-based assisted dying legislation.

In November 2023 the court ruled that **the law made it illegal for telehealth consultations concerning assisted dying to be conducted via carriage services**.

Justice Wendy Abraham found that the word, **suicide**, as used in the criminal code, **applies to the ending of a person's life through voluntary assisted dying**. The ruling prompted independent MP, Kate Chaney, to introduce a bill to federal parliament in February 2024, to amend the Code to make it clear that voluntary assisted dying services are not within the definition of suicide and therefore can be accessed via telehealth and carriage services according to state assisted dying laws. This bill did not proceed to a vote prior to the 2025 election and so far has not proceeded. The Prime Minister, Anthony Albanese, has previously voiced his objection to the notion of assisted dying being captured by telehealth and carriage services.

This court ruling that the law makes it illegal for telehealth consultations concerning assisted dying to be conducted is of particular relevance for any legalisation of VAD in the NT, because the physical isolation of so many patients in the NT who may be subjects of VAD could make the use of Telehealth Services for VAD seemingly very convenient, were it not for the present ban already discussed above.

Health practitioners must be aware that under the Criminal Code Act 1995 (Cth Criminal Code), it is a criminal offence to use telecommunications (e.g. phone, email, or the internet) to disseminate 'suicide related materials', which may extend to providing advice to patients about VAD. As Commonwealth law overrides state law, state legislation provides no protection to health practitioners whose conduct has potential to result in a criminal offence by use of Telehealth consultations related to VAD.

It remains contentious whether telehealth can be used in a limited capacity during the VAD assessment and consultation process. While certain aspects of the process, such as prescribing, would ordinarily be conducted electronically, doing so in these circumstances may contravene Commonwealth criminal law. This uncertainty is particularly concerning for health practitioners in light of the implications raised in the court decision.

Concerns about the potential unlawfulness of telehealth in the context of VAD has increased recently. The Australian Medical Association (AMA) has described the current use of telehealth for VAD as ‘prohibited’ and issued a statement urging the Attorney General to amend the Criminal Code so that health practitioners can provide VAD services via telehealth. This is consistent with the views of various advocacy groups seeking reform to ensure patients living in regional, rural and remote communities have equal access to end-of-life options.

Purpose of the Consultation to which this Submission is Responding

The purpose of the consultation being made by the Legal and Constitutional Affairs Committee of the NT Legislative Assembly is to seek further input on the potential model and implementation of VAD legislation as proposed by the 2024 Expert Panel report paper

This submission will seek to respond to the request for input made by the Consultation Paper.

In brief that Consultation Paper seeks input on:

a) Support for legislating VAD in the NT.
b) Views on the recommendations made in the 2024 Expert Panel Report.
c) Any other issues which the RTLA thinks relevant for consideration by the Committee.

This submission will consider the “Key Questions” which are set out on P.6 of the Consultation Paper:

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

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

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

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

The answers to these questions will be highlighted in the course of this submission.

Terms of Reference of the 2024 Advisory Panel to The NT Government

The Advisory Panel was tasked with providing advice to Government to assist in the consultation and potential development and implementation of a new statutory framework for VAD.

Specifically, the Advisory Panel was to provide advice to the NT Government on an appropriate legal framework for VAD in the NT by answering the following questions:

- **i.** What can the Northern Territory learn from the VAD experience in other jurisdictions, including overseas
- **ii.** Who should be able to access VAD?
- **iii.** What process should a person follow to access VAD?
- **iv.** What models of care should be adopted so that VAD can effectively be delivered in the Northern Territory context?
- **v.** What are the legal and ethical obligations of Health Practitioners who provide services relating to VAD?
- **vi.** What safeguards need to be put in place for those accessing or providing VAD?
- **vii.** How should compliance be monitored? and
- **viii.** Any other question the panel considers appropriate.

We note that these terms of reference of the Advisory Committee effectively ***"begged the question"*** as to the crucial and fundamental issue for the NT Government, namely whether VAD would be legalised in the NT.

Only **Term of Reference 1**, "What can the Northern Territory learn from the VAD experience in other jurisdictions, including overseas?" can in any sense of the phrase be seen as calling for a serious study of the desirability of introducing **VAD** in the NT. This in itself is a very grave defect in the consultation process.

Views on **VAD** and "end-of-life choices", may raise complex and challenging questions. **VAD** is an important ethical, social and legal issue for people in the NT, Australia and internationally, with many arguments for and against its use. **RTLA** accepts the Committee's invitation to consider and present **RTLA**'s views on legalising **VAD** in the NT.

Consultation Topic 1: Legislating VAD in the NT

2024 Expert Panel Recommendation 1

The NT should implement VAD legislation which is broadly consistent with VAD legislation in other states and territories.

The question is then posed:

"Do you support legislating VAD in the NT? Why and why not?

The answer of **RTLA** to this question is a resounding "**No**"!

The core principles of The Right to Life Australia Inc. (**RTLA**) are diametrically opposed to any and all forms of patient killing whether that be by euthanasia, with a physician acting as the killer or be it be by physician assisted suicide.

While the question is put only with regard to "VAD", the **RTLA** reply is to boldly reject any and all forms of patient killing which have been analysed above.

What is so very wrong with such a change as a matter of principle

The context in which the question is put suggests only a modest change in the law. This is far from the reality of such a change. We may ask what is wrong with such a change in the law? The answer is that such a change would radically undermine what is one of the core principles of our very society, namely the principle of the sanctity and inviolability of human life, which has historically been a foundation of our legal system and the whole practice of medicine.

That principle does not require life to be preserved at all costs. It does however prohibit intentional killing and the giving of aid to facilitate assisted suicide, including physician assisted suicide.

Relevant Information from Other Jurisdictions

In the Netherlands the most recent study from 2014 suggests that 3.8% of deaths are by euthanasia or **PAS**, most of which - about 92% of the 3.8% - are by euthanasia. In Belgium, only 4.6% of all deaths in 2014 were by these interventions.

After 17 years of legalisation, in Oregon in2014, only 0.3% of all deaths occurred by **PAS**, and in Washington State only **0.24%** of deaths were by **PAS.**

Not only are these interventions rarely requested, but they are predominantly used by patients with cancer. Even though cancer accounts for less than 25% of deaths in high income countries, about 75% of all euthanasia and PAS cases occur in patients who have cancer.

These interventions are for the **1% not the 99% of dying patients**!

Few occur in patients with neuro-degenerative diseases, such as amyotrophic lateral sclerosis.

These data mean that the claim that legalising euthanasia and PAS will help solve the problem of poor end-of-life care is both erroneous and simplistic.

Euthanasia and PAS do not solve the problem of inadequate symptom management nor do they improve palliative care.

RTLA submits that the NT and along with other jurisdictions still need to deal with the problem that confronts most dying patients:

- how to get optimal symptom relief; and
- how to avoid hospitalisation and so stay at home in the final weeks of life.

Legalising VAD is really a relatively minor medical matter in the overall end-of-life care. It is being championed by the few championed by the few, while the needs of the vast majority of patients can almost be overlooked.

A supporting argument to the position of RTLA comes from a distinguished British House of Lords Committee which in 2005 considered the arguments in favour of PAS and voluntary euthanasia by lethal injections. The focus in that report in 2005 by the House of Lords Select Committee, chaired by Lord Mackay, was the consideration of the *Assisted Dying for the Terminally Ill Bill* introduced by Lord Joffe. The committee rejected the proposals of Lord Joffe, observing that the legal prohibition on intentional killing was the “cornerstone of law and of social relationships” that protects each one of us impartially, embodying the principle that we are all equal.

In other words, we are all equal, however sick, disabled or elderly we may be and however much we may mistakenly think we would be “***better of dead***”. All our lives are worth living.

If legislation were to permit VAD or “physician assisted dying” it would be adopting a new and dangerous moral paradigm such as:

> It is reasonable for *some* members of our community (maybe the “***terminally ill”*** at least for starters) to think of themselves as **“better off dead”**, and that it is right to help them kill themselves

It is highly relevant to look for as much information as is possible from jurisdictions where VAD is legal. It is commonly thought that patients in severe and almost continual pain would want to access VAD. In this light, many healthy people believe that pain would perhaps be the major reason why they want VAD. Let’s look at the evidence.

In the American states of Oregon and Washington, which have the longest experience of the practice of VAD, among the reasons for patients wanting VAD physical suffering not a major issue. However, "being a burden" is the major issue.

The reports published annually for Oregon indicate that physical suffering is not a major issue for those requesting physician assisted suicide.
Of the 1905 people who had died from ingesting a lethal dose of poison between 1998 and 2020 just over one in four (27.4%) mentioned "***inadequate pain control or concern about it***" as a consideration. Earlier annual reports had noted: "*Patients discussing concern about inadequate pain control with their physicians were not necessarily experiencing pain.*" However, in 2019 nearly 6 out of 10 (59.2%) of those who died after taking prescribed lethal medication cited concerns about being a **"*Burden on family, friends/caregivers*"** as a reason for their request. Physician assisted suicide has much more to do with relieving other people of a "***burden***" than relieving unbearable pain. To facilitate VAD for persons simply because they feel they are a burden on family, friends or caregivers sends a cruel message to the elderly, disabled or chronically ill who may need the care and support of others to function in daily life. It implies that only the strong and fully independent have the right to live.

Let's look again at the data from Oregon, between 1998 and 2020, where the reasons for wanting VAD were:

- 90% reported loss of autonomy;
- 90% were less able to engage in activities which made life enjoyable; and
- 70% complained of loss of dignity.

In the Netherlands, the main legal requirement given is "extreme physical or mental suffering," and patients' reasons are classified in this manner, making it hard to know whether the reasons are physical symptoms of depression. However, when researchers in the Netherlands, who were themselves convinced that the main rationale was pain, interviewed patients who had requested euthanasia, they found that few of the ones using euthanasia were experiencing pain, but most were depressed.***2*** The importance of psychological suffering as patients' rationale for requesting VAD indicates that these interventions are less like palliative care and more like traditional suicide condoned and assisted by the medical community.

Since psychological reasons are most cited reasons, one would think that requiring psychiatric evaluation would be a reasonable safeguard before providing VAD.

RTLA submits that we need to examine what may actually lead people to seek VAD in the NT.

The common assumption of many people that with VAD we are dealing with people writhing in intractable pain is simply wrong.

There is also the widespread view that the administration of VAD is easy, uncomplicated and quick.

Further, there is a misleading notion that VAD leads to a peaceful death. Euthanasia and assisted suicide proponents hold out the promise of a peaceful death by fast acting lethal substances. Unfortunately for patients this is frequently far from what they experience as their lives are ended by VAD.

The lethal drugs most likely to be preferred by medical practitioners have been secobarbital and pentobarbital. Between 1998 and 2020, secobarbital had been used in 43.2% of cases and pentobarbital in 20.9% of cases in Oregon. Neither pentobarbital nor secobarbital are now available in the United States so physicians have been experimenting with various lethal cocktails. In Oregon in 2020 nearly all (99.6%) of all deaths by ingesting a lethal dose involved a cocktail in which morphine sulfate was the main lethal substance. These experimental lethal cocktails do not always result in a swift and peaceful death.

In fact, there are reported complications each year from 1998 to 2020, with an overall failure rate of 0.42% (8 people recovered consciousness out of 1905 in those years) and an overall complication rate of 6.3%,52 out of 827 people for whom this data is available. In 2020 there were five cases of complications out of 72 – 6.94% of those for whom information about the circumstances of their deaths is available. This included one case of seizures and 3 cases of difficulty ingesting or regurgitating the poison. In 2019 nearly one in ten (9.84%), and in 2018 nearly one in eight (12.12%) had complications and additionally, one person failed to die and regained consciousness. Two people had seizures in 2017. The interval from ingestion of lethal drugs to unconsciousness has been as long as four hours

In Oregon [1], the time from ingestion to death has been as long as 104 hours in a person who ingested pentobarbital. One person in 2019 took 47 hours to die after using DDMP2 and another person took 19 hours to die after using DDMA. In 2020 one person took 8 hours to die after using DDMA, and another two people took more than 6 hours to die.

Eight people regained consciousness after taking the supposedly lethal dose, including one person in 2018.

In 2005, one patient became unconscious 25 minutes after ingestion, then regained consciousness 65 hours later. This person did not obtain a subsequent prescription, and died 14 days later of the underlying illness – that is 17 days after ingesting the VAD medication.[2]

This patient was lumberjack David Prueitt who, after ingesting the prescribed barbiturates spent three days in a deep coma, then suddenly woke up, asking his wife *"Honey, what the hell happened? Why am I not dead?"* David survived for another 14 days before dying naturally from his cancer.[1]

Since 2005 seven other people have regained consciousness after ingesting the lethal medication. *2010, two patients regained consciousness after ingesting medications. One patient* regained *consciousness 88 hours after ingesting the medication, subsequently dying from underlying illness three months later. The other patient regained consciousness within 24 hours, subsequently dying from underlying illness five days following ingestion.*

In 2011, two patients regained consciousness after ingesting the medication. One of the patients very briefly regained consciousness after ingesting the prescribed medication and died from underlying illness about 30 hours later. The other patient regained consciousness approximately 14 hours after ingesting the medication and died from underlying illness about 38 hours later."[38]

In 2012 "*one patient ingested the medication but regained consciousness before dying of underlying illness ... The patient regained consciousness two days following ingestion, but remained minimally responsive and died six days following ingestion*".[39]

In 2017 "*one patient ingested the medication but regained consciousness before dying from the underlying illness*". In 2018 one person regained consciousness after ingesting the prescribed substance and later died of the underlying illness. Two of the cases of regaining consciousness

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[1] *"Oregon man wakes up after assisted-suicide attempt", Seattle Times, 4 March 2005, http://seattletimes.nwsource.com/html/health/2002197134_webwake04.html*

occurred after using DDMP2 – one of the experimental lethal cocktails being used by pro-assisted suicide doctors.

What We Can Conclude

It is a reasonable conclusion to submit that the common view that VAD is dignified, flawless and painless way to die is quite false.

The evidence which we have presented shows that the case for legalising VAD is less than compelling.

The legalisation and implementation of VAD will not improve the care of patients dying in the NT.

Simply holding out VAD to patients is not helping those patients cope with pain management and enduring inadequately treated physical symptoms.

RTLA asks what then is the great impetus to legalise interventions to deliberately end the lives of patients who are depressed, anxious about losing autonomy and maybe simply tired of life?

We are yet to see the advocates for VAD attempt to present a compelling case for their cause. They resort to glowing, but vague generalities to present VAD as if it were the magic recipe to improve end of life care.

RTLA calls for a focus on improving the quality of care for all patients who are dying and deserve the best possible care within the NT community.

Proposed legislative framework in the NT (2024)

The 2024 Expert Panel Report proposed that the legislative framework in the NT could be consistent with other Australian jurisdictions. The proposal was to develop a VAD Act, regulations, policy and guidelines.

The Consultation Paper proposed that the potential VAD legislation must be developed to suit the NT's unique circumstances.

We endorse that proposal as entirely appropriate.

Harm Minimisation

The Consultation Paper puts the following points for consideration:

1. Emanuel EJ, Onwuchekwa-Philipsen BD, Urwin JW, Cohen J. Attitudes and practices of euthanasia and physician-assisted suicide in the United States, Canada and Europe. JAMA 2016; 316: 79-90.
2. van der Lee ML, van der Bom JG, Swarte NB, et al. Euthanasia & depression: a prospective cohort study among terminally ill cancer patients. J Clin Oncol 2005; 23: 6607-6612.

- What aspects of VAD legislation in other states or territories should or should not be adopted in the NT?
- Given the NT's unique cultural and geographic circumstances, what additional or different safeguards should be included?

In reply to these two questions, the total opposition of **RTLA** to the legalisation of any form of euthanasia or physician assisted suicide means that its response to these questions will always be in terms of harm minimisation.

The report into the development of voluntary assisted dying laws in the NT, recommended the NT Government legalise the practice in line with other Australian jurisdictions. We have no alternative but to accept the reality of this recommendation.

A single, centralised service

This report made 22 recommendations, including that the NT should implement legislation should develop and fund a **"single, centralised service"** for its delivery.

If any forms of euthanasia or physician assisted suicide are to be introduced by law in the NT, the legislation must be rock solid in its harm minimisation and in the inclusion of safeguards to protect any form of abuse upon its implementation.

Removal of Safeguards that "impede access" to VAD

Here it is of significance to point out that currently in Victoria, the government is proceeding with legislation to amend the 2017 Act by, among other amendments, entirely removing two of the safeguards which were most vaunted in the debate in parliament before the Act was passed into law. We refer to the removal of the requirement that medical practitioners acting as the treating doctors not introduce to their patients any mention of euthanasia or doctor assisted suicide.

In light of a review into the operation of the **Voluntary Assisted Dying Act** (**VAD Act**) *t*he Victorian state government has identified several safeguards that ***"impede access, undermining patient-centred care"***. From just that phrase we may conclude that the government is making euthanasia and physician assisted suicide more easily and freely available to Victorians.

Victorian Health Minister Mary-Anne Thomas, who said the state's laws needed updating to remain "fair", confirmed the Government would move to scrap the ban on medical practitioners initiating discussions about voluntary assisted dying with their patients.

Ms Thomas said the Government would also look to expand the six-month life expectancy eligibility rule to 12 months, and to remove the requirement for a third medical opinion for patients with terminal neurodegenerative conditions. The Government also proposes to require doctors who conscientiously object to euthanasia to provide minimum information to patients who raise the option.

The introduction of this bill to amend the VAD Act 2017, which when it was debated in parliament, was touted as the "*safest legislation in the world*", illustrates very clearly the pressure that exists to make euthanasia and physician assisted suicide more freely available once they pass into law. This phenomenon has been widely described as "*the slippery slope*".

After even a minimal examination of VAD legislation in all the states and in the ACT, we have concluded the Victorian **VAD Act** 2017 serves as the best and safest model for the NT to follow, if the NT Government were to decide to introduce VAD legislation into the NT Legislative Assembly

In answer to the second question relating to the NT's unique cultural and geographic circumstances, in the course of this submission we will be particularly mindful as to how the unique circumstances impact on the NT indigenous population spread as it is over such a huge area of 1.35 million Km. After Darwin and Alice Springs, there are only 10 towns with a population greater than 1,000 people according to the 2021 census.

The Australian Bureau of Statistics report on the 2021 census states that 61,000 people responded as being aboriginal. This is 24.5% of the population on the NT.

"Our connection to country is an umbilical cord,"

says Mark Yingiya Guyula MLA

These words of Mark Yingiya Guyula show how important is the bond between aboriginal people and their "country".

A **homeland** is a remote area where a small population of Aboriginal people lives, on lands to which they have traditional or historical ties. There are more than **500** recognised homelands in the NT. Of those, **394** are currently funded to receive municipal and essential services.

Around 7000 people live on homelands, and another 40,000 are linked to a homeland though they live in a larger community. Hence around 47,000 people – more than half of the Aboriginal population of the NT – are directly connected to a **homeland** either because they live there or spend time there with family.

The homelands movement began over 50 years ago. It was a significant development in Aboriginal affairs nationally – a visible demonstration of Aboriginal people across the NT asserting their rights and obligations to their traditional lands.

To this day, residents talk proudly of how they overcame significant barriers through hard work and determination to build their own communities on their ancestral estates as homelands.

Today, homelands are a unique part of the Aboriginal social and cultural landscape, enabling people to live on country, and providing social, spiritual, cultural, health and economic benefits.

The development of legislation around VAD will necessarily involve a recognition of the place of homelands within the indigenous communities in the NT.

- Homelands nourish Aboriginal people and enable them to **sustain cultural practices** including kinship obligations and ceremonies. Many homelands are governed mainly through traditional kinship structures.
- Cultural burning practices mean that homelands country is **healthy country**.
- Homelands give Aboriginal people resources and inspiration to make **wonderful art**.
- During the Covid-19 pandemic, homelands gave alternative and **safe accommodation** for Aboriginal people.

Most homelands are located on Aboriginal land held by Aboriginal land trusts established under the *Aboriginal Land Rights (Northern Territory) Act 1976* (ALRA). A small number have other statutory tenures, such as community living areas (CLAs) or parcels of land within national parks.

The process to formally establish a new homeland with infrastructure usually involves the relevant land council. Generally, housing in homelands is communally owned under the ALRA.

In this policy hole, homeland housing and infrastructure is unregulated and seemingly deteriorating. Homelands are beyond the NT's declared 'building control areas' (where all housing construction must have a building permit and meet the standards for building in the National Construction Code and Building Regulations). As a result, buildings and other infrastructure (power, water and sewerage) may be substandard.

Funding for housing on homelands and for repairs and maintenance was provided by the Commonwealth until 2015, at which time the NT accepted full responsibility for the delivery of municipal and essential services to homelands in exchange for a $155 million cash - out of the municipal and essential services component of the existing funding agreement.

At the time of the transfer of responsibility, the NT Government had no data or baseline evidence to accurately determine the condition of existing assets and essential infrastructure, or the level of unfunded liabilities across homelands. It is likely that the true cost of unfunded liabilities for housing and essential infrastructure across homelands far exceeded the $155 million cash payment, but that is all that was provided.

The NT Government has retained funding responsibility for homelands, but in 2015–16 it spent less than a third of the $155 million it received for homelands. And every year after that it has reduced the funding allocation. In 2022–23 it was $38.6 million. In other words, homelands now receive 28% less funding than they did in 2015–16.

This information shows the situation of the Aboriginal people in the NT's vast area and their practical needs on their homelands. It helps to illustrate the needs of aboriginal people as a backdrop to their health care needs.

Meaning of the phrase "To be on country"

This phrase, **"To be on country"**, is usually something said by aboriginal people when referring to their specific lands. When they're "**on country**" it means they're physically located on the traditional areas of their tribal group.

When we hear the phrase, "**I look forward to welcoming you on country**", - the phrase means, "I look forward to your visit to my tribal area."

It is doubtful if the phrase, **"To be on country"**, also applies to Torres Strait Islanders. They have a slightly different understanding of land and land ownership than Aboriginal peoples.

Inferring that Aboriginal people simply choose to live in remote locations misrepresents and undermines the cultural and social roots which Aboriginal people definitely have. There are many factors that contribute to the complexity of these characteristics. Aboriginal peoples have deep sensitivities, developed over 40,000 years, to live on and care for their traditional “Countries”.

While there are many Aboriginal communities, cultures, and languages, the belief that life is one part of a spirit’s journey is shared by many of the Aboriginal peoples.

When a loved one, extended family member or elder passes away, Aboriginal and Torres Strait Islander people attend to **Sorry Business**–the time after a bereavement where they celebrate the person’s life, honour their death, and assist their spirit on its onward travels.

During this time, an Indigenous person may request cultural leave from their workplace to attend sacred ceremonies, gather with the community to grieve, and participate in events over several days, each with an important meaning, structure, and tradition.

Understanding Sorry Business for First Nations Communities

What is **Sorry Business** in Aboriginal culture?

‘***Sorry Business***’ is a term which has a broad scope, that indicates a valuable time for mourning and where Indigenous people will come together to attend funerals, events, ceremonies, and activities. Rather than holding one funeral and a wake or celebration of life immediately after, as is the norm in Western cultures, Aboriginal people often observe several events over a week or more, where kinship beliefs mean that many people will be welcome and obligated to attend.

Because Aboriginal people may have many mothers and fathers, grandmothers and grandfathers, brothers and sisters, and because life expectancy averages are lower within First Nations communities, these periods of grief and remembrance may last longer and relate to a larger number of individuals whom the person considers their family. Parents and guardians may request a child be granted permission to leave school for these events, and adults may request cultural leave, ensuring they can participate in ceremonies that hold great value and are embedded in cultural traditions, heritage, and respect for those who have been lost.

The Impact of Important Traditions and Beliefs Around Death and Bereavement for Aboriginal People

It is essential to reiterate that Aboriginal groups, tribes, and communities have diverse beliefs, and their approach to death and the afterlife do differ. Many Indigenous communities in the NT, for example, believe that they should not speak the name of the person who has passed away. Speaking their name or showing a photograph may be thought to disturb the spirit and prevent it from leaving safely. Communities often use alternative names, such as ‘Kunmanara’ or ‘Kwementyaye,’ during commemorative ceremonies.

Indigenous Funerals and Periods of Mourning

Families may remain at home for some time following the death of a loved one, followed by cleansing ceremonies. These long-established traditions assist the spirit, help “loved ones” cope with a loss, and send a person safely onto the next part of their journey.

A person with a kinship relationship with the deceased person may feel a strong obligation and responsibility to participate in ***Sorry Business***. Their role within a memorial ceremony or funeral also depend on their kinship system. It is vital for workforces and other parties to recognise that ***Sorry Business*** is not optional or a singular event that an individual can choose whether to attend. Instead, their obligations to a loved one, Elder, or someone with whom they share kinship ties are integral to their culture and connection to the land, community, and people.

Most funerals involve extended communities, where people unite in mourning and provide support for one another. Some may feel unable to attend any other meeting or event while ***Sorry Business*** continues. This is a belief upheld by many First Nations people and respected by organisations and councils within the area. This deep sense of community touches all aspects of life including sickness within the communities

2024 Expert Panel Recommendation 2

The NT should develop and fund a single, centralised service for the delivery of VAD. This should include VAD practitioners, pharmacists and care navigators. Due to the very specific cultural safety concerns related to provision of VAD, the service should be stand-alone and clearly separate from existing NT Health facilities. [2]

Question for Consideration

What are the benefits or challenges you see with a stand-alone VAD service operating separately from existing NT Health?

> We acknowledge the desirability of the recommendation that VAD services be separate from NT Health to ensure cultural safety for Aboriginal residents, who make up 31 per cent of the Territory’s population, and that their needs be addressed if VAD provision were to be provided.

We accept the proposition that there would be unique challenges to delivering VAD in the NT, including access to doctors outside of major

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[2] *Voluntary Assisted Dying Final Report*, above n 4, Recommendation 2.

urban centres, logistical challenges of operating in remote areas, and potential risk to remote staff who are associated with VAD.

To address these challenges, the 2024 Expert Panel Report suggested that VAD may be delivered via a centralised service delivery model. This model would follow the same processes as in other jurisdictions but would be managed and administrated centrally by a service team under the control of an oversight body, such as a Review Board.

This would be a unique model as VAD delivery in all Australian States or Territories is not centralised. In all other Australian jurisdictions, medical practitioners must register as a VAD practitioner and complete any required training. However, they are not separately employed by a centralised VAD service.

NT Health is responsible for six public hospitals in Greater Darwin, Alice Springs, Tennant Creek, Katherine and Gove. Additionally, NT Health supports 39 primary health care centres and supports 133 clinics/services operated by Aboriginal Community Controlled Health Organisations.

Under this proposal, VAD could be implemented via a separate service which is funded and operated separately from existing NT Health services. This would include a co-located, multidisciplinary service covering all parts of the VAD process, including:

Clinicians to undertake assessments and coordination, VAD navigation services including interpreters, and family support.

2024 Expert Panel Recommendation 13

Subject to amendment of Commonwealth legislation, telehealth should be permitted for VAD purposes provided that at least one assessment is carried out in person

As a matter of serious principle RTLA opposes the use of telehealth for VAD purposes.

We note that a serious attempt has been made in the Consultation Paper to find a compromise with regard to the use of Telehealth in VAD process.

The provision being made that at least one of the assessments for VAD be carried out in person is a definite step in the right direction.

RTLA welcomes this step.

This requirement still leaves a substantial role for telehealth in the VAD process. Furthermore, **RTLA** submits that once telehealth becomes a part of the VAD process, it would be only a small step for it to replace "face to face" consultations and become the primary avenue for the approval of VAD in the NT.

The legalisation and availability of telehealth consultations by for example video link for VAD would open the doors to far more readily available access to VAD.

A Little Background: The Offence Of Using A Carriage Service For Suicide-Related Material

It is an offence to use a carriage service for suicide-related material. The offence of using carriage service for suicide-related material is contained in section 474.29A of the ***Criminal Code 1995*** (Cth.)..

Arguments against the Use of Telehealth Consultations for VAD

As a matter of principle, the policy of our federal government is in opposition to suicide. The Australian government has had a National Suicide Prevention Strategy for many years.

For our federal parliament to vote to remove the ban on the use of Carriage Services to facilitate or counsel for suicide to legalise telehealth consultations touching in any way on VAD would be in direct opposition to the government's programmes to combat the prevalence of suicides.

Telehealth consultations touching on VAD would be the most serious and decisive step in the lives of patients. Any consultations between patients and their physicians which involve patients actually requesting access to VAD must, of necessity, be treated with appropriate seriousness because they involve ***"life and death"*** decisions. To allow such ***"life and death"*** consultations to take place by telephone or by video links diminishes the principle of the inherent value of the life of patients.

The prospect of telehealth consultations being allowed within the VAD process and the facilitation of VAD is a first step down a perilous path, in which physicians would be authorised to prepare a path toward the death of patients .

In the case of telehealth consultations for VAD, patients may find it more difficult to verbalise their underlying thoughts on video or audio links. Patients often are experiencing underlying undiagnosed depression.

There may be an interplay of factors relating to their physical and mental health, which in the best of situations impede communication with the physician. We submit that using telehealth would add a further barrier to communication

Such frequently encountered situations require great skills for physicians. Even if they have the required skills, they are unlikely to be able to draw on those skills within telehealth consultations to which patients would be unaccustomed.

The artificial situation of a remote consultation, even if it be via video, will not be one in which such grave issues can be properly resolved for the benefit of patients.

An excellent contribution to the debate is in an article, “Voluntary assisted dying via telehealth is another step down a perilous path”, by Dr Hoa Dinh S.J., published in Eureka Street, 10 June, 2021.

The article has an analysis of the proposal in light of the two main arguments for VAD.

It will be helpful to make extensive quotations from this article with relevant comments.

Dr Dinh notes that critics of this major step argue it is unreasonable to make euthanasia more widely available when palliative care services are still critically lacking in many areas of Australia.

Dr Dinh writes, “The critics cite the recommendation of the Royal Commission into Aged Care Quality and Safety that dementia care and palliative care ought to be the core business of aged care.

“It is vital that VAD legislation ought to balance the liberty of the nonvulnerable against the safeguarding of the vulnerable, especially the elderly and people with disabilities.

He argues that in evaluating the proposed change, “. . . it will be helpful to consider two common arguments in support of VAD.

“First, that it would enhance individual autonomy or self-determination.

“This argument, which featured prominently in the submissions to the 2016 Victorian Parliament Inquiry into End-of-Life Care is often played as the trump card in the euthanasia debate.

“Second, the argument, central to VAD advocacy is that it provides relief for people with existential suffering that palliative care cannot adequately offer.”

Dr Dinh explains that the principle of respect for individual autonomy was introduced into health ethics with the Nuremberg code (1947) responding to the need to safeguard the vulnerable from abuse at the hands of health professionals. Following out of the Nuremberg code, the vulnerability caused by the power imbalance existing between the physician and the patient is now a major concern in health ethics.

He points out, “The Nuremberg code has restricted the power of physicians by making it compulsory for them to obtain informed consent from the participant before making any medical intervention

“The principle of respect for autonomy in health ethics is formulated to address this power imbalance. Its aim is to safeguard the vulnerable from abuse by empowering the vulnerable and simultaneously restricting the power of the physician.

“In Australia today, safeguarding the vulnerable has become mandatory in virtually every sphere of social interaction.

“Now, paradoxically, respect for autonomy is being used to argue for **VAD** legislation.

- It is highly doubtful that there would be adequate be safeguards from exploitation, such as **elder abuse** which is so rampant in Australia today, but is so difficult to detect. This would particularly be the case in telehealth consultations by telephone or video link because the abused patients would find it more difficult to even give a hint of abuse, than might be the case in face to face consultations, in which it is hard to hide the abuse. There is also the added factor that the “**abusers**” may well be surreptitiously present close to patients, unknown and undetected by the medical practitioner conducting the telehealth consultation.

- **The possibility of patients being led to impulsive requests for VAD.**

The pressures, tensions and atmosphere of audio or video consultations to which patients are unaccustomed may actually lead patients to impulsive decisions leading to VAD. With some states already allowing physicians to raise the matter of VAD, vulnerable patients will be exposed during telehealth consultation to greater risks of impulsive decisions and so asking for VAD.

Aboriginal and Torres Strait Islander Cultural Safety

2024 Expert Panel Recommendation 6

The process for addressing Aboriginal and Torres Strait Islander cultural safety issues needs to be designed and resourced as a core part of the operation of legalisation of **VAD.**

The Consultation Paper points out that consideration of the cultural safety of Aboriginal and Torres Strait Islander people would form an important part of **VAD** legislation in the NT.

This is a sensitive issue. Cultural safety is enhanced when health practitioners act with an awareness of cultural contexts, power relations and the rights of individuals.

It is somewhat reassuring that the Consultation Paper recognises that there are diverse views on **VAD** amongst Aboriginal and Torres Strait Islander people who may face specific challenges in the context of a legalized **VAD** service.

Palliative Care Services

The Consultation Paper deals in a balanced way about the interface between palliative care and VAD.

The interface between VAD and palliative care has attracted substantial debate in the different jurisdiction around Australia. We note the observation that some health care professionals may support VAD as an integral element of the palliative care system, other health care professionals see VAD as contradictory to palliative care goals, arguing that VAD would ‘compromise the ethos of palliative care, and thus must be kept distinct’. In Victoria there was majority support for this second view.

There is an extensive, publicly available evidence base for the benefits of a comprehensive palliative care. We submit that within the parameters of healthcare of terminally ill patients in the NT that comprehensive palliative be available and accessible to all who would benefit from such palliative care.

There continues to be a need for better, more available palliative care services in the NT. There are still many people in the NT who do not have access to palliative care services or an appropriate and adequate place of care as their death approaches.

2024 Expert Panel Recommendation 17

Recognising the importance of palliative care services in the NT:

- A person who requests VAD must be informed of all treatment options including the nature, scope and availability of palliative care services.
- Further resources should be provided to educate the community about the nature and scope of palliative care options, particularly for people who wish to remain at home.
- Palliative care services must be consistently and adequately resourced to provide specialised and holistic palliative care to patients, wherever they live in the NT and to address the gaps in those services that result in inequities in people’s end-of-life options.

Implementation of VAD services in the NT must be complementary to, not at the expense of, expanded palliative care resources.[3]

Palliative care is an essential part of the NT's health care system, which faces many challenges in providing palliative care services, given its vast geographical area, high rate of chronic illness and cultural diversity.

Palliative care is the business of every health and community services professional.

A disproportionate number of palliative clients are Aboriginal people, many of whom live outside of urban areas. The key is to ensure that the palliative approach is effectively utilised across the entire health continuum, and to address the needs of people living in rural and remote areas particularly "***on country***", with the challenges this presents.

This strategy demands strong partnerships across the NT, supported by coordinated systems and responses both within the government and non-government sectors. To ensure that people with a life-limiting illness maintain their dignity and have the best possible quality of life, and to ensure that their families and carers receive the best support possible, the NT Department of Health and Community Services needs to continue to offer accessible, quality palliative care services, particularly in light of any future legalisation of VAD.

RTLA recognises that the NT has an expert specialist and primary care workforce that is supported and nurtured to achieve these goals. Effective community engagement across the Territory is another necessary focus for this strategy, with extensive consultation with the range of stakeholder groups.

In the context of the many Aboriginal people who wish to be able to "***die on country***", culturally appropriate palliative care services need to be further developed. In this regard **RTLA** acknowledges the work of the Palliative Care NT as the Northern Territory's peak body for palliative care. We commend its role in raising awareness of palliative care and improve access for all Territorians.

Against the background of those promoting VAD, Palliative Care NT's mission is to influence, foster and promote the delivery of quality palliative care for all Territorians.

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[3] *Voluntary Assisted Dying Final Report*, above n 4, Recommendation 7.

Questions for consideration

- Should health professionals be required to provide information on palliative care options if a person requests VAD?

  2024 Expert Panel **Recommendation 17** states that recognising the importance of palliative care services in the NT, a person who requests VAD must be informed of all treatment options including the nature, scope and availability of palliative care services. RTLA highly endorses this recommendation.

- Should more resources be provided for community education on palliative care?
  - Again, we can quote 2024 Expert Panel **Recommendation 17** which states further resources should be provided to educate the community about the nature and scope of palliative care options, particularly for people who wish to remain at home. In this regard we suggest that flexibility and innovation should be features of palliative care provision for patients living "on country". Mindful that **Recommendation 17** states that further resources should be provided to educate the community about the nature and scope of palliative care options, RTLA submits that substantial funds be made available for that community education **before** there is any implementation of a VAD Act in the NT.
  - Territorians have an improved awareness and understanding of **palliative care** through a framework that incorporates **education**, **advice** and **support** around palliative care. Sound data, continuous evaluation and an evidence base exists to promote development and delivery of palliative care in the NT.

- The Australian Government Department of Health, Disability and Ageing also funds a range of national palliative care projects to enhance the quality of palliative care service delivery and increase support for people who are living with life limiting illness, who require end-of-life care, their families and carers. The overall aim is to improve access to high quality palliative care for all.
- The Program of Experience in the Palliative Approach (**PEPA**) forms part of the **Palliative Care Education and Training Collaborative**. This

Collaborative takes a strategic approach to education and training of the health workforce. It delivers programs for health care provider groups across primary, secondary and tertiary settings.

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- How can it be ensured that VAD services are complementary to, and not at the expense of, palliative care services?
  - In response to this question, implementation of VAD services in the NT must be complementary to, not at the expense of, expanded palliative care resources. This can be ensured if the NT health services are allocated the funds and resources for a comprehensive palliative care service accessible by all residents in the NT.
- Must information on palliative care be delivered by a practitioner with specialised qualifications in the field?
  - This seems a highly desirable stipulation. Nevertheless, in the clinical care of patients it may simply not possible for such a qualified medical practitioner to be available to deliver comprehensive information to terminally ill patients.

Initiating a discussion about VAD

2024 Expert Panel recommendation 12

Medical practitioners should be allowed introduce the subject of VAD services to patients during the discussion about treatment options

An issue of major concern regarding VAD is whether health care providers should be permitted to initiate a conversation about VAD with their patients.

As each State has developed **VAD** legislation, a significant point of debate and decision making has been the limitations, if any, on health care providers initiating the conversation about VAD with their patients.

In Victoria, health practitioners are prohibited from mentioning VAD unless the patient brings up the subject first.[4] Similar provisions exist in SA.

However**,** in WA, Queensland and Tasmania laws permit health practitioners to introduce the topic of VAD[5], as long as they also present all

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[4] *Voluntary Assisted Dying Act 2017* (Vic), s 8.

[5] *Voluntary Assisted Dying Act 2019* (WA), s 10(3); Queensland Health, *Clinical Excellence Division, Guide to Informed Decision-making in Health Care*, p. 60; *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 17(1) and (2).

other options, including continued treatment and palliative care.[6] The ROTI Act took this approach, as well as requiring the practitioner to inform the patient about "counselling and psychiatric support and extraordinary measures for keeping the patient alive, that might be available".[7]

In 2024, it was proposed that in the NT, practitioners would be allowed to initiate discussions about VAD provided that the patient is informed of all treatment options including palliative care.

Questions for consideration

- Should health practitioners be free to initiate a discussion about VAD, providing information alongside other treatment and management options such as palliative care? What other treatment options should be required to be discussed? For example, psychological support.

In many cases in the NT there could exist a huge power imbalance between the patient and the treating health professional.

Can we rule out undue influence if a treating health professional were permitted to introduce the subject of VAD if VAD were to be legalised?

We would expect that any Bill proposed in the NT would require that the subject of VAD must be raised solely and only by a patient voluntarily, with sufficient awareness of the issues at stake and without coercion.

To be truly voluntary a request would need to be not just free of overt coercion but also free from undue influence and free from the subtle pressures which a health professional may bring to bear on a patient.

There is a huge strategic imbalance between the physician and the patient who is terminally ill, as noted above.

A regime in which VAD is made legal and normalised, and in which the physician raises the subject of VAD could well create a framework in which a person with low self-esteem, or who is more susceptible to the influence of others, may well express a request for VAD which the patient would otherwise never have made.

Even this brief discussion of this highly sensitive subject should have made it clear that undue influence could easily be present with devastating consequences for a vulnerable patient.

RTLA adamantly submits that health care providers should not be permitted to initiate a conversation about VAD with their patients during any discussion of health care options.

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[6] *Voluntary Assisted Dying Final Report*, above n 4, p. 63.

[7] *Rights of the Terminally Ill Act 1995* (NT), s 7(e).

What other treatment options should be required to be discussed?

While the area of psychological support was raised above, RTLA wishes to return to the importance of the adequate and comprehensive provision of palliative care for terminally ill patients.

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