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Legal and Constitutional Affairs Committee
Voluntary Assisted Dying Inquiry
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Voluntary Assisted Dying Community Consultation

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1.0 Introduction

Representing our over 94,000 signatories, which includes many from the Northern Territory, the Canberra Declaration is a grassroots network of caring Australians committed to the preservation of faith, family, freedom and life. We affirm the legal reality, etched into the preamble of the Constitution, that Australians are a people "humbly relying on the blessing of Almighty God". We believe that God's blessing will endure in our nation to the extent that we continue to humbly rely on Him. Our vision is to see our country's Judeo-Christian values revitalised for the good of all Australians. We welcome the opportunity to present our submission to this Inquiry.

We stand proudly for our Judeo-Christian values that, when consistently applied, have been the force of an incredible amount of good in the world. In particular relevance to this submission, we put forth that human rights, as we now enjoy them in the modern world, have deep Christian roots.[1] This is seen in the famous words of the United States Declaration of Independence which states, "We hold these truths to be self-evident, that all men are created equal, that they are *endowed by their Creator with certain unalienable Rights*, that among these are *Life*, Liberty and the pursuit of Happiness" (emphasis added). In the Judeo-Christian tradition, humans are not mere animals, but are uniquely made in the image of God (Genesis 1:26–27). The inalienable right to life, also known as 'the sanctity of life', does not include the right to kill ourselves or others. This is our fundamental, ethical disagreement with voluntary assisted dying (VAD).

Although we are fully aware that not all share our Judeo–Christian worldview, we caution that a rejection of it will have consequences such as diminishing the value of human life, and therefore human rights themselves. We will argue that this is exactly what we are witnessing in many jurisdictions that have implemented VAD.

We are immensely proud that our subscribers include many indigenous people. In comparison to many other Australian non-profits, ours enjoys support from a disproportionately large number of indigenous Australians. This is simply because a larger percentage of indigenous people are Christians as compared to the general Australian population. Indigenous Australians, many of whom continue to live in remote, regional areas, may not have ready access to an inquiry such as this one. Thus, we are proud to represent many indigenous Australian Christians in this submission.

We will put forth the case that assisted suicide should not be implemented in the Northern Territory. In making our case in the pages that follow, we are responding to question 1 as provided in the consultation paper.

We also note with dissatisfaction that questions 2-4 are worded in such a way as to assume that the legalisation of VAD in NT is inevitable. We wish to put on record our

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[1] Kurt Mahlburg, "10 Reasons Our Human Rights Come from Jesus", *Daily Declaration*, 17 April 2019, <https://dailydeclaration.org.au/2019/04/17/ten-reasons-our-human-rights-come-from-jesus/>.

serious concern that this wording undermines the transparency and legitimacy of the present inquiry.

By way of summary, our recommendations are as follows:

- Recommendation 1: Increase funding for gold-standard, culturally sensitive palliative care to provide compassionate, life-affirming support for Territorians, ensuring access to ethical end-of-life care without diverting resources to assisted suicide.

- Recommendation 2: The NT Government should avoid euphemistic terms like “voluntary assisted dying” or “VAD substance” and instead use precise terminology such as “assisted suicide” and “lethal agent” to ensure legal, ethical, and cultural clarity, particularly given the NT’s diverse linguistic context.

- Recommendation 3: Conduct a transparent, community-wide consultation on the ethics of assisted suicide to address the foundational ethical concerns ignored in the current inquiry’s framing.

- Recommendation 4: The Northern Territory must reject the legalisation of assisted suicide, as it undermines the sanctity of human life, contradicts the ethical stance of key medical bodies, and becomes increasingly common in scope and number, as evidenced in other jurisdictions.

Thank you for taking the time to review our submission.

Sincerely,

The Canberra Declaration

2.0 Definition of Terms

Clearly defined terms are essential to accurate communication. In addressing an issue as important as Voluntary Assisted Dying (VAD), the correct definition of terms is all-important—especially in a jurisdiction as culturally and linguistically diverse as the Northern Territory (NT). Ambiguous or euphemistic language not only confuses the public but also creates ethical, legal, and cultural risks. Misleading terminology can undermine the sanctity of life, erode trust, and endanger public understanding of complex end-of-life issues.

This section critiques the terminology used in the NT's consultation paper and demonstrates why clarity is necessary to ensure informed debate, especially around the ethically sensitive and legally complex issue of voluntary assisted suicide.

2.1 Why Legally and Ethically Precise Terminology Matters

The NT can learn from Victoria in using precise definitions of terms. The Australian Care Alliance, in their submission to the Committee, highlighted the motivation behind using phrases like "voluntary assisted dying" instead of "assisted suicide." They correctly state:

> Australian State laws on "voluntary assisted dying" attempt to exclude the intentional causing of a person's death by self- or practitioner-administration of a lethal substance from the category of suicide.

However, in a judgment handed down on 30 November 2023, the Federal Court ruled that this linguistic distinction is invalid. In Carr v Attorney-General (Cth) [2023] FCA 1500, the court found:

> "Suicide" in the Criminal Code Act 1995 (Cth) does apply to conduct undertaken in accordance with and authorised by Victorian legislation, including the Voluntary Assisted Dying Act 2017 (Vic) and the Voluntary Assisted Dying Regulations 2018 (Vic).

This legal precedent confirms that what is called "voluntary assisted dying" is, in law, a form of suicide.

Suicide is defined as "the act or an instance of taking one's own life voluntarily and intentionally." Since this is exactly what VAD permits—either through self-administration or practitioner-administered means—the term "voluntary assisted dying" is not only ethically imprecise but legally misleading.

2.2 Euphemistic and Ambiguous Framing

The term "voluntary assisted dying" is a euphemism that obscures the true nature of the act—intentional life termination. By framing VAD as an "end-of-life choice" akin to palliative

care or withdrawal of treatment, the consultation paper implies it is a benign form of medical care. This conflation is deeply misleading.

Palliative care aims to relieve pain and improve quality of life; it does not hasten death. In contrast, VAD involves the direct and intentional ending of a life, whether by the patient or a medical practitioner.

The consultation paper's definition—"the use of a prescribed substance to cause the death of a person who is terminally ill at their request"—fails to distinguish between:

- **Voluntary euthanasia**: where a medical professional administers the substance.
- **Assisted suicide**: where the patient self-administers a substance provided by a professional.

This ambiguity matters. These are not interchangeable practices. Each has distinct ethical, legal, and medical implications.

2.3 Cultural and Linguistic Risks in the NT Context

The NT's unique cultural and linguistic diversity—with over 200 languages spoken—demands extreme care in how policies involving death and dying are communicated. Cultural sensitivities, particularly within Aboriginal and Torres Strait Islander communities, mean that vague or euphemistic terms like "VAD" risk misinterpretation and confusion.

If even well-established medical terms like "palliative care" are difficult to translate into local languages, newer, politically charged concepts like "VAD" will only create further uncertainty. In such a context, informed consent becomes virtually impossible without clear, direct, and culturally respectful language.

2.4 False Neutrality and Devaluation of Life

The phrase "voluntary assisted dying" implies neutrality, but in practice it normalises the idea that some lives are no longer worth living. This undermines the core legal and medical principle that all human beings have equal inherent dignity and value.

Any legal framework that authorises the intentional ending of life—especially one that lacks linguistic and conceptual precision—inevitably embeds discriminatory assumptions about whose life is worth preserving. This is incompatible with the non-discrimination principles of both Australian law and international human rights norms.

2.5 Voluntary Assisted Suicide Is Not Palliative Care

There is a fundamental and irreconcilable difference between palliative care and assisted suicide. Palliative care is rooted in compassion, aiming to alleviate suffering through care and sympathy, and affirms life by relieving pain and improving quality of life without

hastening death. In contrast, assisted suicide involves the intentional ending of life, either through direct action or omission. These opposing aims create a deep ethical divide that cannot be reconciled within a unified model of care.

Expecting palliative care services or practitioners to participate in assisted suicide undermines the core principles of their practice and risks causing significant moral distress. This has been observed in jurisdictions such as Canada, where the legalisation of assisted suicide has contributed to healthcare providers leaving the profession due to the conflict with their ethical duty to protect life.

Legalising assisted suicide risks diverting resources and public trust from palliative care services, which offer compassionate and ethical end-of-life support without resorting to life-ending measures. The reason is simple: assisted suicide will, over time, increasingly be perceived as a cheaper alternative to developing comprehensive palliative care solutions for complex patient needs.

Recommendation 1: Increase funding for gold-standard, culturally sensitive palliative care to provide compassionate, life-affirming support for Territorians, ensuring access to ethical end-of-life care without diverting resources to assisted suicide.

2.6 Narrow Definitions Obscure Broader Ethical Violations

The consultation paper's narrow focus on the act of administering a lethal substance to a terminally ill person neglects broader ethical considerations—such as intentional life termination by omission (e.g. withdrawing treatment to hasten death). This omission distorts the ethical conversation and falsely presents assisted suicide as safe and clearly defined, when in reality, its boundaries are fluid and susceptible to abuse.

In the NT, where access to healthcare is already uneven, any legalisation of assisted suicide would introduce significant risks of coercion, misapplication, and irreversible harm.

2.7 The Misleading Neutrality of the Term "VAD Substance"

The consultation paper repeatedly uses the term "VAD substance" to describe the prescribed agent employed to intentionally end a life. While seemingly clinical and neutral, this terminology masks the gravity of the act it facilitates: the deliberate administration or self-administration of a lethal chemical substance for the purpose of causing death.

Recommendation 2: The NT Government should avoid euphemistic terms like "voluntary assisted dying" or "VAD substance" and instead use precise terminology such as "assisted suicide" and "lethal agent" to ensure legal, ethical, and cultural clarity, particularly given the NT's diverse linguistic context.

3.0 Learning From Other Jurisdictions

We commend the Legal and Constitutional Affairs Committee for asking this question, as invaluable wisdom can be gained from the experience of others. The experience of other jurisdictions demonstrates that assisted suicide should not be legislated in the Northern Territory.

3.1 Addressing the Foundational Ethical Issue

We are deeply concerned that the Legal and Constitutional Affairs Committee is repeating the same mistake made by other Australian jurisdictions, namely, ignoring the foundational ethical issue of whether it is right for a doctor to kill a patient or to assist the patient to kill him or herself.

Legalising assisted suicide denies the inherent worth of every human life, a principle foundational to justice. By allowing doctors to act on the belief that some lives are not worthwhile, assisted suicide legislation subverts the state's duty to protect all citizens equally, eroding the moral basis of civil authority.

The NT Government page set up for this inquiry strongly indicates that it supports assisted suicide and considers it a human right. The inquiry page states, "The Northern Territory community is *entitled* to make choices to manage their end of life care, *as are all other Australians*."[2] This statement is in the context that other jurisdictions have already implemented assisted suicide, with the strong implication it should be implemented in the NT as well.

In addition, the inquiry page states that "The NT Government is carrying out community consultation to develop a framework for VAD."[3] Concerningly, the consultation paper has not asked the public whether they believe assisted suicide is ethical in the first place. Instead, it presumes it without any justification and only asks questions about *how* it should be implemented.

This is entirely unacceptable. We echo the words of former Prime Minister Paul Keating and urge the Legal and Constitutional Affairs Committee to learn from his words when the same debate was had in Victoria:

> The justifications offered by the bill's advocates – that the legal conditions are stringent or that the regime being authorised will be conservative – miss the point entirely. What matters is the core intention of the law. *What matters is the ethical threshold being crossed. What matters is that under Victorian law there will be people whose lives we honour and those we believe are better off dead.*
>
> In both practical and moral terms, it is misleading to think allowing people to terminate their life is without consequence for the entire society. *Too much of the Victorian debate*

[2] Northern Territory Government, "Voluntary assisted dying", <https://cmc.nt.gov.au/project-management-office/voluntary-assisted-dying>.
[3] Ibid.

has been about the details and conditions under which people can be terminated and too little about the golden principles that would be abandoned by our legislature.[4]

Paul Keating's warning went unheeded in Victoria. We urge that the same mistake is not made in the Northern Territory.

<u>Recommendation 3</u>: Conduct a transparent, community-wide consultation on the ethics of assisted suicide to address the foundational ethical concerns ignored in the current inquiry's framing.

3.2 Relaxation of Restrictions over Time

The consultation paper emphatically states that "VAD is *not* a way for a person who is *not* terminally ill to end their life" (emphasis added). However, this is a highly misleading statement. Historically, the legalisation of voluntary suicide has very often ultimately led to non-terminally ill people ending their lives.

Examples from many jurisdictions demonstrate that once assisted suicide is introduced, restrictions are relaxed over time. This point is not surprising. Once the threshold is crossed that assisted suicide is ethical in some circumstances, it becomes easier to increasingly expand the situations in which it can take place. As former Prime Minister Paul Keating wisely put it, "The culture of dying, despite certain and intense resistance, will gradually permeate into our medical, health, social and institutional arrangements. It stands for everything a truly civil society should stand against."[5] Sadly, his words have been proven true in tragic practice.

3.2.1 Australia

Australian assisted suicide legislation has progressively weakened initial safeguards over time, illustrating a clear expansion of access beyond original limits.[6] Victoria's 2017 law initially restricted eligibility to those with a prognosis of six months—or twelve months for neurodegenerative conditions—and limited euthanasia to practitioner administration only when self-administration was impossible.

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[4] Paul Keating, "Voluntary euthanasia is a threshold moment for Australia, and one we should not cross", *Sydney Morning Herald*, October 19, 2017, <https://www.smh.com.au/opinion/paul-keating-voluntary-euthanasia-is-a-threshold-moment-for-australia-and-one-we-should-not-cross-20171019-gz412h.html>, emphasis added.

[5] Paul Keating, "Voluntary euthanasia is a threshold moment for Australia, and one we should not cross", *Sydney Morning Herald*, October 19, 2017, <https://www.smh.com.au/opinion/paul-keating-voluntary-euthanasia-is-a-threshold-moment-for-australia-and-one-we-should-not-cross-20171019-gz412h.html>.

[6] Jones, David Albert, "Wrong Side of the World: The Misplaced Reliance on Australia in the UK Debate on 'Assisted Dying'," The Anscombe Bioethics Centre. https://bioethics.org.uk/media/4a1pb3b3/wrong-side-of-the-world-the-misplaced-reliance-on-australia-in-the-uk-debate-on-assisted-dying-prof-david-albert-jones.pdf.

However, subsequent laws in Queensland (2021) and the Australian Capital Territory (2024) have relaxed these restrictions by permitting euthanasia when self-administration is deemed "inappropriate" and offering patients a choice between euthanasia and self-administration.

Unlike Oregon's tightly controlled model restricted to terminally ill patients, Australian jurisdictions have broadened eligibility to include individuals without strictly terminal conditions, moving closer to Canada's permissive Medical Assistance in Dying framework. This trajectory demonstrates the ongoing erosion of safeguards and the normalisation of assisted suicide for a wider population, suggesting further expansions are likely.

Additionally, unlike US jurisdictions, which provide statutory protections for institutions like hospices to opt out of facilitating assisted suicide, Australian states often require institutions to participate in assisted suicide, with the ACT even criminalising failure to facilitate it. This lack of conscientious objection protections for institutions risks coercing healthcare providers and facilities into participating, potentially normalising assisted suicide and pressuring vulnerable patients to consider it as a default option, further evidencing the slippery slope toward broader societal acceptance of assisted suicide.[7]

3.2.2 Belgium

Belgium legalised assisted suicide in 2002 and set the age limit to those 18 and above. However, in 2014, this age restriction was removed. Only two years later in 2016, *CNN* reported that Belgium's first minor used assisted suicide to die.[8] Of extra relevance is that minors were initially intended to be included in the assisted suicide law in 2002. However, due to public backlash, they were excluded.[9] Nevertheless, as this example from Belgium demonstrates, once the threshold is crossed, it becomes easier to relax restrictions.

Of additional importance is the rationale given for the death of this minor by Belgian lawmaker Sen. Jean-Jacques De Gucht. Commenting on this very instance, Gucht stated, "I think it's very important that we, as a society, have given the opportunity to those people to decide for themselves in what manner they cope with that situation."[10]

Belgium made assisted suicide legal for those with "constant and unbearable physical or mental suffering that cannot be alleviated."[11] The question must be asked: If it is a human right to access assisted suicide in such circumstances, why shouldn't this 'right' be

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[7] Jones, David Albert, "Wrong Side of the World: The Misplaced Reliance on Australia in the UK Debate on 'Assisted Dying'," The Anscombe Bioethics Centre. https://bioethics.org.uk/media/4a1pb3b3/wrong-side-of-the-world-the-misplaced-reliance-on-australia-in-the-uk-debate-on-assisted-dying-prof-david-albert-jones.pdf.
[8] Chandrika Narayan, "First child dies by euthanasia in Belgium", *CNN*, 17 September 2017, <https://edition.cnn.com/2016/09/17/health/belgium-minor-euthanasia/index.html>.
[9] Ibid.
[10] Ibid.
[11] Laura Smith-Spark and Diana Magnay, "Belgium: Lawmakers vote for children's 'right to die' euthanasia law", *CNN*, 13 February 2014, <https://edition.cnn.com/2014/02/13/world/europe/belgium-euthanasia-law-children>.

afforded to minors? If assisted suicide truly falls under 'palliative care' and is an ethically valid form of health care, why should such 'health care' be denied for people who haven't revolved around the sun enough times?

3.2.3 Netherlands

The Netherlands was the first country to legalise assisted suicide in 2002.[12] The law was introduced with age restrictions, but it already made provisions for minors 12 years and older to access assisted suicide in certain cases. However, last year, access to assisted suicide widened to include children of all ages.[13]

To repeat, once assisted suicide is legalised, the push to expand its horizons continues to gather momentum.

In addition, the story of Gaby Olthuis provides a very troubling example of how assisted suicide can become acceptable for purposes that were not originally intended. Gaby was a 47-year-old woman who had persistent ringing in her ears (tinnitus).[14] In 2014 she died by assisted suicide at an end-of-life clinic. Tragically, she left behind two teenage children – a boy aged 13 and a girl, 15.[15]

Furthermore, in the Netherlands, assisted suicide eligibility has expanded to include non-terminal conditions like psychiatric disorders and dementia, with euthanasia for psychiatric disorders increasing over 600% and for dementia over 400% from 2012 to 2020 in the Netherlands.[16] This slippery slope risks endangering NT's vulnerable populations, such as those with mental health challenges, if assisted suicide is legalised.

The NT must learn from the Dutch experience, where legalising voluntary euthanasia led to widespread non-voluntary euthanasia (over half of 10,558 euthanasia deaths in 1990 were without explicit request), showing that once the ethical line of intentional killing is crossed, it becomes impossible to contain.

The Dutch case illustrates that legalising voluntary euthanasia paves the way for non-voluntary euthanasia, as advocates like the Royal Dutch Medical Association shifted from supporting only voluntary euthanasia to endorsing non-voluntary practices, driven by the logic that if killing benefits some, it should not be denied to others unable to request it. This

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[12] Andrew Osborn, "Mercy killing now legal in Netherlands", *The Guardian*, 1 April 2002, <https://www.theguardian.com/world/2002/apr/01/andrewosborn>.
[13] Lenore Taylor, "Netherlands to broaden euthanasia rules to cover children of all ages", *The Guardian*, 15 April 2023, <https://www.theguardian.com/society/2023/apr/14/netherlands-to-broaden-euthanasia-rules-to-cover-children-of-all-ages>.
[14] Sue Reid, "The country where death is now just a lifestyle choice: A mum with ringing ears. Babies whose parents don't want them to suffer. They've all been allowed to die by assisted suicide in Holland", *Daily Mail*, 2 January 2015, <https://www.dailymail.co.uk/news/article-2893778/As-debate-assisted-suicide-dispatch-Holland-thousands-choose-die-year.html>.
[15] Ibid.
[16] Van der Heide, Agnes, et al. 'End-of-life decisions in the Netherlands over 25 years.' New England Journal of Medicine 377.5 (2017): 492-494.

slippery slope threatens vulnerable populations in the NT, where healthcare access is already limited.

3.2.4 Canada

Canada's experience with Medical Assistance in Dying (MAiD) offers a stark example of how quickly life-ending practices can become normalised once legalised. In just four years, from 2016 to 2020, the number of MAiD deaths increased more than sevenfold—from 1,018 to 7,595. By 2020, assisted suicide accounted for 2.5% of all deaths in the country. This rapid growth demonstrates how legalisation can shift cultural and medical norms around death, with serious implications for other jurisdictions considering similar pathways.

The expansion of MAiD in Canada has also affected the doctor-patient relationship. Physicians are now required to inform patients about MAiD if they meet eligibility criteria, even when the patient is seeking other forms of medical or social support. This practice can create a subtle but real pressure toward choosing death, particularly for vulnerable individuals who may be struggling with chronic illness, disability, or social disadvantage.

Such systemic pressures are especially concerning in remote communities, where access to quality healthcare and social services is already limited. Normalising assisted suicide in these contexts risks further eroding trust in the healthcare system and may contribute to a sense of abandonment rather than care.

The Northern Territory should take caution from Canada's example. Once the ethical threshold of state-sanctioned killing is crossed, reversing course is difficult. The Canadian model reveals how quickly assisted suicide can expand in scope and volume, challenging the foundational medical ethic of preserving life and threatening the broader societal commitment to protecting the vulnerable.

3.3 Assisted Suicide Becomes Increasingly Acceptable

Canada first introduced assisted suicide in 2016. In 2017, almost 3,000 Canadians chose this form of death. Sadly, the most recently released statistics reveal this number climbed significantly to 10,064 in 2021.[17] While saddening, these statistics are not surprising. Wherever they are passed, assisted suicide laws have the effect of liberalising social attitudes towards this form of death.

A Canadian poll by Research Co. is a case in point. Conducted last year, the poll found that 28% of Canadians viewed homelessness as a ground for assisted suicide.[18] An almost identical number (27%) gave poverty as a legitimate reason. Very concerningly, half of

[17]Health Canada, "Third Annual Report on Medical Assistance in Dying in Canada, 2021", <https://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying/annual-report-2021/annual-report-2021.pdf>, 18.
[18] Mario Canseco, "Most Canadians Back Status Quo on Medical Assistance in Dying", *Research Co.*, 5 May 2023, <https://researchco.ca/2023/05/05/maid-canada-2023>.

Canadians thought "inability to receive medical treatment" (51%) or a disability (50%) should make people eligible for assisted suicide.[19] For people suffering from mental illness, 43% agreed that assisted suicide was valid.[20] Without a doubt, the introduction of legalised assisted suicide creates an impression in the population that it is ethically acceptable, and for an increasing number of reasons.

A further tragic case of the use of assisted suicide occurred in 2022. A 51-year-old Ontario woman who suffered from severe sensitivities to chemicals required "affordable housing free of cigarette smoke and chemical cleaners".[21] Her desperate search for two years failed, and in response, she chose assisted suicide. In a video eight days before her death, she recorded, "The government sees me as expendable trash, a complainer, useless and a pain in the a**".[22] Legalising assisted suicide inevitably degrades the value of human life.

Sadly, the attitude that some people are better off dead than alive pervades Canada. Military veteran and paraplegic paralympian Christine Gauthier, who competed for Canada at the 2016 Rio de Janeiro Paralympics, testified before the Canadian parliament that the Department of Veterans Affairs offered her, in writing, assisted suicide.[23] Gauthier had been fighting for funding for a wheelchair ramp for her home for five years, but, to that point, to no avail. The former Paralympian testified, "I have a letter saying that if you're so desperate, madam, we can offer you MAID, medical assistance in dying".[24] Thankfully, Prime Minister Justin Trudeau called Gauthier's treatment "absolutely unacceptable". But with half of Canadians agreeing that disability is a valid ground for assisted suicide should the person ask for it, is it much of a surprise that the option is given to a disabled person to accept or reject—paralympian or not?

For further evidence that legalising assisted suicide risks embedding the belief that some lives are no longer worth living, consider Belgium, where euthanasia has been legal for years, and euthanasia cases citing both physical and psychological suffering rose from 78.8% in 2018 to 82.8% in 2019. Even more troubling, cases involving only psychological suffering increased from 3.5% to 4.3%.

Moreover, in Oregon, one of the earliest jurisdictions to legalise assisted suicide, the top reasons cited for choosing death are not pain, but rather loss of autonomy (90.9%) and a diminished ability to engage in enjoyable activities (90.2%). Only 27.5% cite pain as the reason. These figures suggest that assisted suicide may be less about terminal illness and more about difficulty coping with disability or dependence—raising red flags for the

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[19] Ibid.
[20] Ibid.
[21] Avis Favaro, "Woman with chemical sensitivities chose medically-assisted death after failed bid to get better housing", *CTV News*, 14 April 2022 (updated 25 August 2022), <https://www.ctvnews.ca/health/woman-with-chemical-sensitivities-chose-medically-assisted-death-after-failed-bid-to-get-better-housing-1.5860579>.
[22] Ibid.
[23] Murray Brewster, "Former paralympian tells MPs veterans department offered her assisted death", *CBC News*, 1 December 2022, <https://www.cbc.ca/news/politics/christine-gauthier-assisted-death-macaulay-1.6671721>.
[24] Ibid.

Northern Territory's ageing and disabled populations who deserve support, not subtle encouragement toward death.

Finally, the consultation paper itself rightly notes that "the number of people accessing VAD is increasing in other Australian jurisdictions," but fails to address the alarming scale of this trend. According to the data in the table provided on page 12 of the consultation paper, over just two years, there has been a national average increase of approximately **104.5%** in the number of people accessing assisted suicide —effectively more than doubling. This steep rise cannot be dismissed as minor or incidental.

While relatively few people may access assisted suicide in the early stages of legalisation, the experience of other states shows that demand grows rapidly, placing increasing pressure on health systems to normalise and expand access. In a jurisdiction like the Northern Territory—with unique geographical, cultural, and health-service challenges—this growth could stretch resources and accelerate the cultural shift toward viewing death as a default solution to suffering.

The Northern Territory must resist this shift, as legalising assisted suicide risks reshaping cultural attitudes to see death as a logical response to suffering, dependency, or vulnerability. These trends reveal how quickly societal norms can shift once such laws are introduced. In the NT—where Indigenous communities are especially sensitive to issues surrounding death—this could foster a dangerous acceptance of life-ending measures as a remedy for hardship. Such a shift undermines the principle that all lives possess equal dignity and worth, and erodes the moral barrier that protects society's most vulnerable, including the disabled, elderly, and poor.

3.4 Non-Assisted Suicide Remains the Same or Increases

Often an argument made in favour of assisted suicide is that it will lower non-assisted suicide rates. However, this argument is, sadly, terribly weak.

3.4.1 Victoria

Prominent in the push for assisted suicide in Victoria was the argument that its introduction would lower the suicide rate, particularly amongst the elderly and terminally ill. Television journalist Andrew Denton repeatedly used this justification for the introduction of assisted suicide across Australia.[25] Denton's Go Gentle organisation states that the number one reason in favour of assisted suicide is that "Too many Australians are dying 'bad' deaths".[26] It argues that the testimony of state coroners unequivocally points to "horrific suicides in

[25] David A. Jones, "Did the Voluntary Assisted Dying Act 2017 Prevent 'at least one suicide every week'?", *Journal of Ethics in Mental Health*, vol. 11 (2003), <https://jemh.ca/issues/open/documents/Did%20the%20Voluntary%20Assisted%20Dying%20Act%202017.pdf>.
[26] "8 reasons why all states must pass assisted dying laws", Go Gentle, 4 February 2020, <https://www.gogentleaustralia.org.au/8_reasons_why_all_australian_states_must_pass_voluntary_assisted_dying_laws>.

the absence of VAD laws. The Victorian Coroner revealed these suicides were happening at the rate of one a week in Victoria."[27] In particular, Denton rightly emphasised that the focus was upon "elderly Victorians" who are most at risk of terminal illnesses.[28]

It is now possible to evaluate whether the introduction of assisted suicide has reduced the non-assisted *elder* suicide rate in Victoria. Assisted suicide was implemented in Victoria on 19 June 2019. In 2018 and 2019, the number of non-assisted suicides was 102. In the subsequent three years, non-assisted suicides in this cohort have risen to 107, 118 and 156 for the years 2020, 2021 and 2022, respectively. An analysis in the *Journal of Ethics in Mental Health* observes:

> Between 2018 and 2022 the increase was 54 elderly suicides. Rather than a reduction of "at least one suicide every week"… there has been an unwelcome increase of approximately one suicide a week.[29]

The upward trend in Victoria in elder non-assisted suicides is alarming, particularly when in NSW during that time, they decreased – a time in which NSW did not have assisted suicide. (NSW introduced assisted suicide in 2023.)

The same journal report concludes:

> Given the prominence of the appeal to suicide prevention for the debate in Victoria… and given that the anticipated benefits were in particular for "frail, elderly and vulnerable Victorians"… this lack of empirical confirmation of impact is concerning.[30]
>
> Those jurisdictions considering a change in the law should be sceptical of the argument that was so prominent in Victoria, unless and until evidence is found that implementation of assisted dying actually leads to fewer unassisted suicides.[31]

This troubling rise in elder suicides has prompted reflection on the broader cultural implications of assisted suicide. Note that between 2019 and 2022, suicides among Victorians aged 65 and older—the demographic most directly targeted by assisted suicide legislation—increased by over 50%, from 102 to 156. In contrast, suicide rates among those under 65 remained stable.

This pattern has led some to suggest that the legalisation of assisted suicide may inadvertently convey the message that the lives of older individuals facing illness or hardship are less worth preserving. Rather than alleviating despair, the availability of assisted suicide might reinforce feelings of burden, isolation, or hopelessness, potentially exacerbating the very suffering it was intended to relieve.

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[27] Ibid.
[28] Jones, "Did the Voluntary Assisted Dying Act 2017 Prevent 'at least one suicide every week'?": 9.
[29] Ibid.: 11.
[30] Ibid.: 14.
[31] Ibid.: 14.

3.4.2 Netherlands

In 2001, the year before it introduced assisted suicide, the Netherlands' suicide rate was 9.6 per 100,000 people.[32] In 2019, the suicide rate was hovering just under 12%, meaning non-assisted suicide has increased by around 10%.[33] The Netherlands offers no evidence that assisted suicide lowers the rate of non-assisted suicide. Sadly, the fact is quite the opposite. Legalising assisted suicide legitimises all suicides. When the statistics for assisted suicide are included in the overall suicide rate, there is a staggering 110% increase since 2002.[34]

<u>Recommendation 4</u>: The Northern Territory must reject the legalisation of assisted suicide, as it undermines the sanctity of human life, contradicts the ethical stance of key medical bodies, and becomes increasingly common in scope and number, as evidenced in other jurisdictions.

4.0 Safeguards

Unfortunately, the consultation paper's discussion of safeguards assumes that it is possible to put safeguards in place around assisted suicide. This assumption is fundamentally flawed and must be rejected.

Some proponents of assisted suicide have agreed that such safeguards are indeed impossible. But disturbingly, the impossibility of such safeguards is, to them, no argument against assisted suicide. For example, renowned British neurosurgeon Henry Marsh remarked about assisted suicide, "Even if a few grannies get bullied into it, isn't that the price worth paying for all the people who could die with dignity?"[35]

Once again we cite with approval Paul Keating who succinctly answered this issue with these words:

> An alarming aspect of the debate is the claim that safeguards can be provided at every step to protect the vulnerable. This claim exposes the bald utopianism of the project – the advocates support a bill to authorise termination of life in the name of compassion, while at the same time claiming they can guarantee protection of the vulnerable, the depressed and the poor.
>
> *No law and no process can achieve that objective. This is the point*.[36]

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[32] "Netherlands Suicide Rate 2000–2024", *Macrotrends LLC*, <https://www.macrotrends.net/countries/NLD/netherlands/suicide-rate>, citing World Bank data source.
[33] Ibid.
[34] "Euthanasia", Cherish Life, n.d., <https://www.cherishlife.au/euthanasia>.
[35] Henry Marsh, as quoted in Zosia Chustecka, "Renowned Neurosurgeon on Assisted Dying and His 'Suicide Kit'", Medscape, <https://www.medscape.com/viewarticle/879187?form=fpf>.
[36] Paul Keating, "Voluntary euthanasia is a threshold moment for Australia, and one we should not cross", *Sydney Morning Herald*, October 19, 2017, <https://www.smh.com.au/opinion/paul-keating-

We urge the Legal and Constitutional Affairs Committee to consider that medical bodies routinely oppose assisted suicide. For example, the Australian Medical Association position paper states:

> The AMA believes that doctors should not be involved in interventions that have as their primary intention the ending of a person's life. This does not include the discontinuation of treatments that are of no medical benefit to a dying patient.[37]

In other words, doctors should kill the pain, not the patient. The AMA goes on to make these additional points:

> For most patients at the end of life, pain and other causes of suffering can be alleviated through the provision of good quality end of life care, including palliative care that focuses on symptom relief, the prevention of suffering and improvement of quality of life. There are some instances where it is difficult to achieve satisfactory relief of suffering.[38]

The AMA makes it clear that palliative care achieves desirable outcomes in the improvement of quality of life in pain management for most patients. In those instances where it is difficult to achieve satisfactory relief of suffering, sedation can be used "to keep the dying patient comfortable, whether to allow a brief 'time out' at peaks of pain, or to manage terminal symptoms."[39]

In addition, the Australian and New Zealand Society for Palliative Medicine and the Australian Medical Association do not support assisted suicide.[40] Neither does the World Medical Association.[41]

We urge the Legal and Constitutional Affairs Committee to seriously consider that if it recommends assisted suicide, it is unwisely doing so against the advice of these top medical bodies.

Finally, we wholeheartedly endorse the submission made by the Australian Care Alliance. We urge the panel to consider the twelve reasons that 'wrongful death' can occur under assisted suicide as reasons why assisted suicide must be abandoned entirely. We find the arguments put forth by the Australian Care Alliance rigorously argued and irrefutable, but

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voluntary-euthanasia-is-a-threshold-moment-for-australia-and-one-we-should-not-cross-20171019-gz412h.html>, emphasis added.

[37] Australian Medical Association, "AMA Position Statement: Euthanasia and Physician Assisted Suicide", 2016, <https://www.ama.com.au/sites/default/files/documents/AMA_Position_Statement_on_Euthanasia_and_Physician_Assisted_Suicide_2016.pdf>.

[38] Ibid.

[39] "Euthanasia", Cherish Life, n.d., <https://www.cherishlife.au/euthanasia>.

[40] Cherish Life Newsletter, vol. 49, no. 2 (2021): 6, <https://www.cherishlife.au/wp-content/uploads/2023/06/Anti-Euthanasia-Advocacy-newsletter-Cherish-Life-Winter-2021.pdf>.

[41] "Euthanasia", Cherish Life, n.d., <https://www.cherishlife.au/euthanasia>.

we will not repeat them here. Instead, we will simply quote their conclusion, which we endorse:

> If no scheme for "voluntary assisted dying", thus defined, can effectively prevent wrongful deaths – of the 12 categories set out in the submission - then it would be unsafe for Territorians for the legislature to enact such a scheme and the proposal by the Government to consider doing so should be abandoned.
>
> It is the considered position of the Australian Care Alliance, based on all the available evidence, that none of the jurisdictions that have legalised euthanasia and/or assisted suicide have succeeded in establishing a safe assisted suicide/euthanasia framework.[42]

5.0 Conclusions

We strongly urge the Committee to reject the legalisation of assisted suicide in the Northern Territory. Though often framed as a compassionate response to suffering, this policy carries profound ethical, cultural, and social consequences that undermine the equal dignity of all Territorians.

Assisted suicide is being promoted under the claim that it is a human right, that it entails no broader consequences for the value of life, and that palliative care is insufficient. These claims are not supported by evidence. In fact, this submission demonstrates they are both philosophically and practically untenable.

The term *"voluntary assisted dying"* is a euphemism that obscures the reality: it is the intentional termination of human life. In a jurisdiction as linguistically and culturally diverse as the NT, such language risks serious misunderstanding. More critically, it distorts the ethical debate, presenting a sanitised version of what is, at its core, a life-ending practice.

Experiences from other jurisdictions—such as Canada, Belgium, the Netherlands, and Victoria—show that once assisted suicide is legalised, it expands in both scope and social acceptance. Canada's MAiD deaths made up 2.5% of all deaths by 2020, a figure that continues to rise. Belgium has extended access to minors; the Netherlands permits it for psychiatric conditions. Victoria saw a 50% increase in elderly suicides after legalisation, belying claims that assisted suicide reduces other forms of suicide.

These outcomes reflect more than policy drift—they reveal a shift in moral norms. The practice signals that some lives are no longer worth preserving, particularly for the vulnerable: the elderly, disabled, mentally ill, and terminally ill. The impact on Indigenous communities—many of whom have deep spiritual and cultural sensitivities around death—would be especially damaging.

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[42] "Submission to the Northern Territory's Legal and Constitutional Affairs Committee on Voluntary Assisted Dying Legislation by the Australian Care Alliance", Australian Care Alliance, <https://assets.nationbuilder.com/australiancarealliance/pages/171/attachments/original/1704931585/Australian_Care_Alliance_submission_to_NT_Expert_Advisory_Panel.pdf?1704931585>.

Legalising assisted suicide also undermines trust in the healthcare system. Safeguards are repeatedly shown to be fragile, and even proponents acknowledge they are difficult to enforce. The Australian Medical Association remains opposed to the practice, affirming instead the value of palliative care, which seeks to comfort without killing.

The normalisation of suicide—assisted or otherwise—inevitably erodes society's commitment to the inherent and equal value of every human life. Already, suicide rates are rising globally. When a society begins to endorse suicide as a solution to suffering, it sends a dangerous message: that death is preferable to dependence, disability, or despair.

We are, slowly but unmistakably, cultivating a *"culture of dying"*—one that shapes not only individual choices but institutional policies, medical ethics, and social attitudes. This culture stands in direct contradiction to what a civil and compassionate society should uphold.

We therefore call on the Committee to reject the introduction of assisted suicide in the Northern Territory. Instead, we urge greater investment in culturally sensitive palliative care, broader community education on end-of-life options, and a transparent, inclusive ethical consultation that affirms the dignity of every Territorian.