

The VAD experience around Australia

an assessment by

Ethical End of Life Care

Ethical End of Life Care Limited is a not-for-profit company limited by guarantee. Our vision is to seek an Australian society where assisted suicide and euthanasia (VAD) are recognised as dangerous and harmful, and where better, ethical solutions are upheld to care for persons living with illness, disability or suffering. We have many supporters who are health professionals, and we are also supported by others who share our vision. Our Board comprises a broad range of medical practitioners, academics and others who share our vision.

Overview

Voluntary Assisted Dying (“VAD”) laws have been in operation in different Australian states for a number of years.

The experience of VAD around Australia to date can be summarised as follows:

Change in attitudes:

1. Following the introduction of VAD, the ethos within the medical profession has begun to move away from the practitioner’s primary duty being to strive to solve the problems causing the patient to contemplate suicide and towards the practitioner validating a patient’s consideration of VAD and advising the patient how to go about it.
2. Thus, for example, doctors, regulators and academics have supported patients obtaining VAD for reasons such as being a burden on the family, with little apparent regard for finding alternative solutions for their distress.
3. The change in attitudes is being made more pervasive because doctors who are not supportive of VAD are often being forced out of the public hospital system due to pressure and fear of adverse professional consequences. This reduces the ability of patients who don’t want VAD to be cared for by practitioners who support their wish to die a natural death without VAD intervention.
4. There is a grave risk that over time the legalising of VAD will lead to doctors forming the view that a patient ought to be opting for VAD and thereby becoming inclined to regard patients as being unreasonable if they refuse to do so.
5. Legalising VAD can also change attitudes within families away from striving to get help for their loved one toward thinking that if Parliament says VAD is OK, it must be OK, so perhaps it is the best way forward to end the suffering the whole family is experiencing.

Choosing between death and avoidable pain:

1. There are widespread shortfalls of palliative care across Australia, yet governments have prioritised VAD provision over improving palliative care. Indeed, there has been a decrease in palliative care availability in some jurisdictions.
2. While for a few patients, VAD will be what they want regardless, for many patients, inadequate palliative care leaves them with a choice between VAD and dying in avoidable pain due to inadequate palliative care.
3. It seems an outrage for any Parliament or government to leave terminally ill patients with that choice – “We could relieve your pain, but we’ll offer you death instead.” The solution to inadequate palliative care is improving the quality of that care, not VAD.

Things going wrong:

1. Many doctors who are involved in VAD are ignorant of what palliative care can do or biased against palliative care and in favour of VAD, and thus there’s a high risk they will misadvise patients.
2. Many doctors who are involved in VAD are advising patients whose underlying condition is outside their field of qualification, expertise or experience.
3. Doctors involved in VAD are often going to be unable to detect risk factors such as lack of capacity, depression or other mental health issues, undue influence or coercion.
4. There’s been a concentration of VAD practice in the hands of a small number of one-eyed VAD supporting doctors.
5. Especially where doctors can initiate a discussion about VAD, their doing so can be taken by many patients as an implicit recommendation of VAD, especially by disadvantaged patients. Even without doctors initiating discussion, the way a doctor responds to a patient who raises the subject also risks being taken as an implicit recommendation, whether or not that is what the doctor intends.

No effective and impartial oversight:

1. VAD regulators, and the doctors who serve on those regulators, have inherent conflicts of interest because they are part of the system they are supposed to be regulating, and/or they are long-standing VAD supporters.
2. Because it would weaken public support for VAD for failures or abuses to come to light, these regulators have an unavoidable interest in turning blind eyes to failures or at minimum avoiding them becoming public.
3. There are no post-mortems, random case audits or other follow-ups to see if the diagnosis of the patient’s condition was correct or whether there were any other issues of concern.
4. The coroner is generally excluded from investigating VAD cases, as is also proposed in the ROTI Bill.

From this experience, clear conclusions can be drawn about what the Territory can expect if VAD is introduced.

VAD regimes around Australia

What is the basic structure of current VAD regimes around Australia? How similar are they to the ROTI Bill?

All VAD regimes around Australia have the same basic structure, which the ROTI Bill follows. The structure is based on the model first introduced in Victoria in 2017, and then adopted in all other states, although with progressively fewer safeguards.

Under this structure, a patient who is considering VAD is assessed by two doctors, generally referred to as the coordinating practitioner and the consulting practitioner. If they both conclude the patient is eligible, there is a final sign-off process, and then the VAD can proceed. VAD takes place either by the patient self-administering a lethal substance, or through a practitioner doing so. Where both options are readily available, most administration is done by a practitioner.

The different state models have various different specifications for eligibility, the required prognosis, the qualifications and experience of the assessing and/or administering practitioners, the sign-off for VAD to proceed, the dispensing of the lethal substance, the availability of conscientious objection, the role of the Review Board and the scope for external scrutiny.

A good example to follow?

Does the experience to date show that VAD is working well?

The answer is no. Under the VAD regimes that operate in the various states:

- There are widespread shortages of palliative care
- Minimal qualifications or experience are required for the doctors involved in discussing, recommending, assessing or administering VAD
- Minimal training is required for determining whether patients have adequate legal capacity, are not depressed or experiencing other mental health issues and are free of coercion or undue influence
- There has been a high concentration of cases with a small number of doctors
- There is no independent and impartial oversight or regulation
- The coroner is excluded from looking at VAD cases
- There are no requirements to report adverse events
- There are no audits of actual compliance or random case reviews
- Doctors who disagree with VAD are being forced out of public hospitals
- Having medically assisted suicides hasn't reduced other suicides

As well, many front-line doctors don't have good knowledge of a patient's condition or of what palliative care can do, yet they are the ones who are often providing the first advice to patients about their options, and whose poorly informed advice can turn patients away from getting better advice and instead start them on the path to VAD. This is because what a patient's doctor tells them about VAD can easily be taken by the patient as an implicit

recommendation, especially by disadvantaged and vulnerable patients and those brought up to believe that doctor knows best.

Furthermore, many inexperienced doctors fail to recognise that the way they suggest consideration of VAD as an option can cause patients enormous unnecessary angst and pre-occupation, depriving them of time and peace of mind when they could instead have been connecting with loved ones, creating memories and making sense of the life they have lived.

Most insidious of all is that the legalisation of VAD is progressively changing attitudes in the medical profession away from practitioners trying to do whatever they can to help solve the problems that are causing their patient to want to die, and instead towards feeling that it's the patient's choice so the practitioner's role is simply to tell the patient how they can obtain VAD if they want it.

Qualifications and experience

What qualifications and experience do doctors need to have before they can assess patients for VAD?

The usual basic requirement in VAD regimes is for the assessing practitioners either to be registered as a medical specialist or to have specialist registration as a GP (which most Australian GPs have), and to have practised for at least a year after obtaining their specialist registration. Different states may add other requirements.

However, there's generally no requirement for either of the assessing doctors to be a specialist in the patient's condition, nor any requirement for either doctor to have any particular level of knowledge about palliative care, nor is there anything to stop both assessing GPs from being in the same clinic or other practice.

The ROTI Bill has all these shortcomings and more, as the Bill allows one or both practitioners to be GPs who haven't even obtained specialist registration, as long as they have practised as a GP for 5 years (cl.87, cl.88). Although Bill allows the Chief Health Officer to set other "approved requirements" (cl.136), it is not clear what those requirements may be or whether they can require practitioners to have additional qualifications or experience. The Explanatory Memorandum for the Bill says only that "The intention is to enable an administrative verification process, including for example, referee checks, to ensure practitioners have the necessary professional attributes to perform the role.", which suggests the provision is aimed at requirements other than qualifications or experience.

All this means that under the ROTI Bill, a patient can be assessed and approved for VAD by two GPs who haven't obtained specialist GP registration, and who work down the corridor from one another in the same general practice or clinic, neither of whom has any prior experience of the patient's illness, and neither of whom knows anything much about palliative care or about available treatment options.

Training

Does the extra training doctors that have to undertake before assessing VAD patients ensure they know how to perform VAD assessments and advise patients?

No. The training in the various states follows the same basic and limited model.

In Victoria, for example, the training for eligibility to dispense VAD consists solely of an online module that takes just six to eight hours to take. Of that, only 5 minutes cover judging whether a request is voluntary and detecting risk factors such as coercion, and just over 3 minutes cover other eligibility requirements such as diagnosis and time to death.

Most of the training is about how to follow the required procedural steps and how to get the paperwork right.

Given that the ROTI Bill uses the same basic model as the various States, it can be expected that the required training approved by the CHO (cl.135) will be similar and will also be heavily focussed on procedural requirements, with only minimal regard to assessing risk factors and little if anything to ensure the practitioner understands what could be achieved by alternative options such as specialist palliative care and pain management.

Ensuring compliance

Is anything done to make sure the requirements are actually being complied with?

No Under the states' VAD models, there are no audits of actual compliance, or requirements for random case reviews, so as to find out and report on what actually occurred and whether there were any lessons to be learned, such as a reviewer interviewing family members, or the deceased's GP, or social workers or others, so as to see whether there were any concerns about factors such undue pressure, or lack of capacity, or mental illness, or else to make sure the assessing doctors had been aware of any such concerns and had properly taken them into account.

There's also no requirement for any doctor or other health professional involved to report adverse events, such as the lethal substance not working properly, or suspicious circumstances about whether the death was truly voluntary when allegedly self-administered.

As well, the models specifically exclude the coroner from looking at any deaths where the substance was taken in accordance with the legislation, so there's no possibility of any post-mortem being done to make sure the diagnosis of terminal illness was correct or, indeed, to see if there is any evidence of complications or distress in dying.

The ROTI Bill repeats all of these failures. Although one of the functions of the Review Board is to review each completed VAD request (cl.108), the experience of the various states shows that this will almost certainly be a review based on the paperwork alone – paperwork that is provided by the assessing practitioners themselves, and which is hardly likely to disclose any failures to comply.

While the Review Board is empowered to "request" any person to give information to the Board (cl.122), it is given no general power to compel the giving of information, and giving a power to "request" shows that the Bill does not intent to give a general power to compel. The only power of compulsion in the Bill is that the Board can require the coordinating practitioner, the contact person or the administering practitioner to provide information about the person's death (cl.86). However, that does not allow the Board to require the provision of information about the assessment process, which is where any failures to comply with the legislation are most likely to have occurred.

When an administering practitioner administers the lethal substance, they must report that fact to the Review Board and certify that the consent was voluntary and the patient had

legal capacity (cl.61). Where the patient self-administers, or dies by other means, the coordinating practitioner, and/or the practitioner who reports the death to the Registrar of Births, Deaths and Marriages, is required to report the death to the Review Board (cl.85). However, in neither case is the reporting practitioner required to inform the Board of any complications in dying or of any other adverse events, nor of any suspicious circumstances of a death where a practitioner does not administer.

The ROTI Bill also excludes the Territory Coroner from looking at any deaths where the lethal substance was taken in accordance with the legislation (cl.152), so there's no possibility of any post-mortem being done to make sure the diagnosis of terminal illness was correct or, indeed, to see if there is any evidence of complications or distress in dying.

While in theory the Territory Coroner could investigate a death if the lethal substance was not administered in accordance with the legislation, in the absence of any case audits or reviews, or requirements to report suspicious circumstances, this is unlikely ever to be discovered in the first place.

Furthermore, the exclusion of the fact that a person has died from VAD, not only from the person's death certificate, but even from the doctor's formal notification of the death to the Registrar of Births, Deaths and Marriages, omits important information from those records and diminishes transparency and accountability.

Oversight and regulation

What do Review Boards do to oversee the operation of the regime and make sure the legislation is being complied with?

The Review Boards in various states are made up mainly of members who have a strong commitment to VAD. This has meant their role has been little more than that of a cheerleader rather than that of an independent and impartial regulator. The Boards tell the public how well things are working regardless of the facts, they avoid publication of any contrary evidence, and they lobby for further expansion to the law.

As a result, there can be hints of problems in Review Boards' annual reports, but no details are given, and Boards simply say the problems are now under control. In some reports, for example, there have been hints but nothing more about issues such as problems with prolonged time to death, and problems where the assessing doctors haven't complied with the legislation.

A lot of these failures of oversight go back to the overall structure of the original Victorian VAD model, which was then largely replicated in other States, and which give every impression of having been based on a maxim of "hear no evil, see no evil, speak no evil" – in other words, to find out nothing, investigate nothing and report nothing that could suggest VAD has been anything other than a complete success.

Thus, the entire structure of the Victorian Act, for example, gives the impression it has been set up so that nothing that could reflect adversely on VAD can come to light:

- the paperwork is completed by the assessing doctors, who are committed to VAD,
- it is checked by public servants, who work in a department committed to VAD,
- the regime is overseen by a Review Board committed to VAD,
- there are no opportunities for third parties to raise red flags at any stage,

- there is no independent verification of the facts before a permit to go ahead is issued,
- there are no reviews or follow-ups after a death other than of the paperwork, and
- the only potential independent reviewer – the coroner – is shut out of almost any involvement.

It is fundamental to any regulatory regime that its oversight is independent, impartial and objective and it is a massive regulatory failure where there's no such oversight.

The Review Board provisions of the ROTI Bill depart from this model in various respects, but this creates its own problems. Under the Bill, the Board is chaired by the CHO (cl.110), and its members are appointed on the recommendation of the CHO (cl.111). As well, NT Health staff are not involved in issuing approvals for VAD cases to proceed, so the staff supporting the Review Board will not have that conflict.

However, the ROTI Bill's model makes the impartiality and operation of the Review Board crucially dependent on how well the CHO performs their role and who the CHO recommends for appointment to the Review Board. If, any time, the CHO of the day is not committed to the impartial operation of the Review Board, the Board can readily be the same sort of cheerleader for VAD as in the various states. Furthermore, because the CHO has various roles under the legislation in issuing guidelines, prescribing training and setting other approved requirements, as chair of the Review Board, the CHO can face a conflict of interest in reviewing the adequacy and effectiveness of their own work.

To make matters worse, even if the CHO and the Review Board members are keen to do their job impartially and vigilantly, for the reasons discussed under "Ensuring compliance" above, the Bill does not give the Review Board the information gathering or case review powers it needs in order to be a genuine and effective reviewer of VAD cases and a protector against abuses or other failures.

In short, even with the best will in the world, the ROTI Bill's Review Board can be little more than a toothless tiger, lacking the capacity to give either MPs or the public confidence that the attempted safeguards in the NT's VAD regime are operating effectively and that patients do not end up choosing to die by VAD due to misinformation or poor advice.

Concentration with few doctors

What has been the concentration of VAD cases among practitioners, and what have been its implications?

The number of doctors who do the assessing for VAD in the various states is highly concentrated.

For example, in Victoria in the most recent year reported (2024-25), half of all assessments for VAD were submitted by just 32 doctors. The Territory's smaller population and fewer doctors mean that assessments are likely to be even more concentrated with just a handful of doctors. Indeed, this was exactly what happened when the Territory previously legalised euthanasia, when just one doctor, Dr Philip Nitschke, was involved in every case in which a patient's life was ended.

While VAD advocates have argued that concentrations of cases have been due to allegedly onerous training or other factors, it seems more likely that it has been because many doctors simply don't agree with VAD and don't want to have anything to do with it, despite all the pressure applied within the health system to promote acceptance.

The problem with the sort of concentration that has occurred, and which is likely to occur in the Territory, is that many patients are being counselled by doctors who have a strong personal commitment to VAD, which makes it highly likely that those doctors will be dismissive of what palliative care can do, and will be far less likely to detect factors such as undue pressure, lack of capacity or mental illness, because they will be convinced that VAD is the right thing for the patient and thus unquestioning about why the patient is asking for it.

Treatment of conscientious objectors

Is it true that doctors who disagree with VAD are being forced out of public hospitals?

Yes, to varying degrees, the governments and health departments in various states have pushed public hospitals to make VAD readily available and to brook no dissent from any of their practitioners.

This is despite the fact that, on paper, health practitioners in other states are given similar rights not to participate as those in the ROTI Bill.

The result has been that many health practitioners working in public hospitals in various states now feel unable to raise concerns about VAD, including about the ways VAD is being implemented within their hospital, either generally or individual cases.

This has led many senior and experienced practitioners to leave the public hospital system, or even to cease practising entirely, while those who remain are forced to bite their tongues in order to avoid adverse professional or career consequences.

When VAD was legalised, it was presented as an option that would be available for the relatively small number of people who wanted it, while things would continue unchanged for everyone else.

However, it has turned out to be the opposite. The way the regime is working around Australia is pushing one particular view about appropriate end-of-life care onto everyone, whether they agree with it or not. Many healthcare and other providers have strong objections to VAD for a variety of reasons, including that it is inconsistent with sound medical practice and/or due to concern and compassion for those who might be making misguided decisions to end their lives.

Driving out those providers diminishes the overall level and diversity of health care that is available to patients, and it especially diminishes the range of providers whom patients can access knowing that those providers do not support VAD and will not be seeking to encourage their patients to access VAD.

While a small number of people may want VAD, most patients with life threatening illnesses want the best treatment they can obtain and want the best possible palliative care and support in their final days. They do not want to find themselves being treated in a health system where increasingly there is an implication that they should be thinking about VAD instead, and where over time doctors increasingly are likely to regard patients as being unreasonable if they continue to refuse VAD.

Effect on other suicides

Has the availability of medically assisted suicides helped reduce the number of other suicides?

There's no evidence that has been the case, and indeed there's evidence of the opposite.

A study in 2023 found that there had been no reduction in general suicide in Victoria compared with other Australian states in the time when VAD was available in Victoria but not in other states. The study also found that there is some evidence of an increase in suicides amongst those aged 65 and over. See <https://irp.cdn-website.com/c0d44f22/files/uploaded/Did the Voluntary Assisted Dying Act 2017.pdf>

Non-medical suicides by terminally ill people in large part consist of those who end their life impulsively, such as by jumping from a multi-storey car park after being given adverse test results by their oncologist. Legalising assisted suicide is not likely to avert such suicides. Others who end their lives by non-medical suicide do so in circumstances of loneliness and lack of support. An emblematic example of this that was raised in the Victorian debate about VAD was a suicide by a person who was alone and whose condition had deprived her of her lifetime pleasure of reading. Rather than this showing the need for VAD, the compassionate community response should be to make it easier for people in such a situation to receive more home visits or for someone to sit and read to them.

Palliative care

What has happened with palliative care in Australia since VAD was legalised?

There are ongoing serious shortages of palliative care in Australia, despite what some have claimed.

This leaves many Australians faced with a choice between VAD and dying in pain due to inadequate palliative care.

For example, the Australian Medical Association has warned that in parts of Sydney it takes weeks for patients to get to see a palliative care doctor. The AMA has rightly described this situation as "heartless and inhumane". See <https://www.amansw.com.au/palliative-care-cuts-cruel-and-heartless-for-the-most-vulnerable-patients/>

Palliative Care Australia has estimated that more than three in five people who are dying from a terminal illness in Australia don't receive specialist palliative care at any stage. See <https://palliativecare.org.au/campaign/better-access-to-palliative-care-worth-voting-for/>

The human face of this lack of palliative care, despite the legalisation of VAD in all states, is shown by the harrowing account given on the same Palliative Care Australia web page of the painful and distressing death experienced by a family member due delayed and inadequate palliative care availability, even in a public hospital, coupled with a lack of understanding by many hospital staff of the patient's palliative care needs.

As well as the shortages of adequate palliative care, there is a lack of high-quality aged care and nursing home facilities across the country. Poor living conditions and inadequate care in such facilities can also drive people to choose VAD, because of their poor quality of life in those circumstances. As with shortages of palliative care, the solution to inadequate nursing home and aged care is improving the quality and availability of that care, not VAD.

Despite shortages and inadequacies such as these, once VAD has been legalised, governments and health administrators have given far greater priority to making VAD universally available than they have given to making palliative care universally available.

So, for example, in Victoria the government has set up a statewide, dedicated, lethal substance delivery service, but it hasn't set up a statewide pain medication delivery service.

This has been defended on the basis that pain relief is available through standard pharmacy access, whereas without a delivery service it would be hard to get VAD substances in remote areas. However, this ignores the fact that it is also hard, if not impossible, for patients to obtain home delivered pain relief in remote areas. Yet the Victorian government chose to overcome the former problem for dying patients but not the latter.

In other words, a patient will receive gold standard service if they want VAD; they receive bronze standard service if they want care and pain relief.

Similarly, under the ROTI Bill, there is provision for a dedicated "navigator service" to provide support and assistance relating to VAD, but there is no similar dedicated "navigator service" for those who want palliative care or pain relief, despite the legislation's title proclaiming that it is about the rights of terminally ill patients in general, not just about the rights of those who want VAD, and despite remoteness in the Territory being as great a problem as in Victoria, if not greater.

There have been figures cited that purport to show that most VAD patients in various states have been able to receive palliative care. However, very broad definitions are used for what amounts to "receiving palliative care", so that those figures do nothing to indicate whether those VAD recipients were actually receiving the level of palliative care they needed or whether they were simply on the books of a palliative care provider or receiving inadequate basic or limited care from an overstretched service.

Needless to say, wherever there are shortfalls in palliative care, it means patients can end up accepting VAD as a very poor second choice - one they wouldn't have chosen if they could have obtained the palliative care they needed and desperately wanted.

Implications for the Territory

Are there implications of the states' experience for the debate on the ROTI Bill?

The experience in the various states has a range of implications for the ROTI Bill.

Perhaps the most serious of all is that one can expect that legalising VAD in the Territory will over time start to change attitudes in the medical profession away from giving priority to trying to do whatever the practitioner can to help solve the problems that are causing their patient to want to die, and instead towards practitioners feeling that it's the patient's choice so the doctor's role is simply to give the patient factual information and tell them how they can obtain VAD if they want it.

It is also likely to change attitudes of families and friends away from fighting to get the best possible care for their loved one and towards thinking that if Parliament says VAD is a legitimate option, then it must be an acceptable option, so perhaps it's the best way to bring an end to the distress the whole family is suffering. Conflict about this within families can be an unnecessary added burden for a person approaching the end of their life.

Secondly, many patients in the Territory, as is happening already in other parts of Australia, are likely to be left with a choice between VAD and a painful death due to inadequate palliative care.

Of course, VAD is not in fact needed to avoid painful deaths. Painful deaths are what MPs and others advocating VAD usually point to as the reason for legalising VAD, but VAD practitioners themselves usually don't make that claim, probably because they know that today, almost without exception, pain and other physical symptoms can be resolved by proper palliative care. Palliative care experts have pointed this out time and time again - that the various examples of allegedly unavoidably painful deaths cited by MPs in previous debates could have been avoided with proper palliative care.

It's particularly ironic that MPs and others campaigning for VAD give examples of painful deaths as their reason for wanting it, when what their examples really show is the need for better palliative care – yet that's the very palliative care that can so easily be neglected if VAD is legalised.

It is also ironic that the unjustified claims about painful deaths constantly being raised by VAD advocates are themselves likely to lead many patients to undergo VAD because of the fear created by those claims, whereas if they had not felt driven to VAD, they would have found that their fears were unfounded.

Thirdly, if VAD is legalised in the Territory, things are going to go wrong for patients and the regime created by the Bill will be unable to detect or prevent that happening.

For example, as in other parts of Australia, legalising VAD will make it almost inevitable that many front-line treating doctors having the first conversations about VAD with their patients won't have a good knowledge of palliative care or of the patient's condition, yet the way they discuss the subject without that knowledge will be taken as an implicit recommendation by the patient, whereas if the patient had been given accurate information about their treatment and palliative care options, they would not have chosen VAD.

It is also almost inevitable that assessing doctors will often have great difficulties in telling whether a patient's request for VAD is voluntary and fully informed, or whether it is being made in situations of family violence, elder abuse or other improper influence, or whether the patient has a lack of capacity or a mental illness such as depression. None of that can be remedied simply by putting a provision in a Bill stating that the doctors need to check for those factors.

Thirdly, if the assessments are not done by doctors with true expertise in the patient's condition, there will be a serious risk of wrong diagnoses where patient isn't terminally ill at all, and of wrong prognoses that are wildly inaccurate, meaning a patient who accepts VAD will be missing out potentially on years of fulfilling life ahead. The way the states' VAD regimes – and the proposed Territory regime – are set up, these errors will simply never come to light. People will die prematurely based on misdiagnosis and no one will ever know.

In addition, there is always a risk that a few doctors will be willing to completely push the envelope to provide VAD to their patients even if the law isn't being complied with.

Furthermore, the intended safeguard of requiring the concurrence of two doctors is undermined by allowing the coordinating practitioner to seek concurrence from one consulting practitioner after another until they find a consulting practitioner who will agree with them that the patient is eligible. The only check against this practice is if the Review Board notices it and is prepared to query it.

Furthermore, in the Territory as in other parts of Australia, there will no adequate scrutiny or fully independent oversight. As with other Review Boards, the Territory's Review Board is given only limited powers to obtain further information, and it will also have a fundamental conflict of interest, because the Chief Health Officer, who chairs the Board, and who recommends the other appointees, will be in the position of monitoring, judging and reporting on their own performance of the roles given to the CHO under the legislation, such as issuing guidelines, prescribing training and setting other approved requirements, and there are no truly independent outsiders, such as the Territory Coroner, specified as members of the Review Board. There is also little assurance in the Bill about the range of data that will be collected and made public about the operation of the regime, which is left highly open-ended.

When all these implications are put together, it is manifest that the regime proposed in the ROTI Bill, as with any regime for VAD, will have serious and systemic risks that are inherent and can't be avoided regardless of what attempted safeguards or system of oversight are put in the legislation, so that any benefits for the few that might come from legalising VAD will be vastly outweighed by the harms that will flow to the many.

The only way to avoid those harms is to not introduce any form of VAD regime and therefore to reject the ROTI Bill.

Some might argue that this will put the Territory out of step with the rest of Australia. However, the rest of Australia is out of step with the most of rest of the world when it comes to legalising VAD. The majority of European countries, the majority of the United States and the vast majority of the rest of the world continue to treat euthanasia and assisted suicide as the dangerous and harmful practices that they are.