Submission to the Legal & Constitutional Affairs Committee Inquiry into Voluntary Assisted Dying in the Northern Territory

Australian Medical Association Northern Territory

28th August 2025

Introduction

The Australian Medical Association Northern Territory (AMA NT) welcomes the opportunity to provide this submission to the Legal and Constitutional Affairs Committee's Inquiry into Voluntary Assisted Dying (VAD). This submission is guided by the national Australian Medical Association's (AMA) Position Statement on Voluntary Assisted Dying 2025, which was updated following extensive member consultation to reflect the legislative landscape where VAD is a lawful choice in every Australian state.

The AMA NT supports the introduction of carefully regulated VAD legislation in the Northern Territory. This position is founded on the fundamental principle of ensuring equitable access for all Territorians to healthcare choices that are legally available to all other Australians. The prohibition of VAD in the Northern Territory, while it is lawful elsewhere, creates an inequitable and unjust situation for Territorians at the end of life.

The AMA has always acknowledged and respected the wide spectrum of deeply held personal and professional views on VAD within the medical profession and the broader community. This submission, therefore, is not intended to advocate for or against the moral permissibility of VAD itself. Rather, its purpose is to provide an evidence-based, ethical, and practical framework to support the development of legislation that protects and supports both the doctors and patients who choose to participate in VAD, and those who, for reasons of conscience, choose not to.

The AMA NT appreciates the Committee's diligent work on this sensitive and significant issue. We remain committed to advocating for a VAD framework that prioritises patient safety, ensures equitable access, respects the diverse needs of Territorians—particularly those in remote communities and Aboriginal and Torres Strait Islander peoples—and upholds the professional and ethical responsibilities of medical practitioners. We trust that our input will assist the Committee in developing robust, compassionate, and context-specific VAD legislation for the Northern Territory.

Table of Contents

Core Principles

This submission is structured around four non-negotiable principles that the AMA NT believes must form the bedrock of any VAD legislation and service delivery model in the Northern Territory. These principles are derived from the national AMA position, the evidence from other jurisdictions, and a pragmatic understanding of the Territory's unique context.

1. **The Primacy of High-Quality Palliative Care**: Investment in VAD must never be at the expense of, nor compromise the provision and resourcing of, high-quality palliative care. Palliative care and VAD are distinct services. No patient should ever feel compelled to explore VAD because they are unable to access timely, comprehensive, and culturally safe palliative and end-of-life care.
2. **Robust and Defensible Safeguards**: The legislative framework must be evidence-based, nationally consistent where appropriate, and ensure clear, rigorous, and transparent safeguards. These safeguards must protect all patients, particularly those who may be vulnerable, and ensure that participation in VAD remains entirely voluntary for both patients and medical practitioners. The framework must also provide absolute legal protection for practitioners acting lawfully within its provisions.
3. **Workforce Support, Training, and Resourcing**: A safe, effective, and accessible VAD system is entirely dependent on a medical and healthcare workforce that is appropriately educated, trained, resourced, supported, and remunerated. This includes mandatory training, access to counselling and debriefing services, and clear clinical guidelines.
4. **A Model Tailored for the Northern Territory**: The NT's unique geographic, demographic, and cultural landscape demands a bespoke service delivery model. A framework simply transposed from a metropolitan southern state will fail. The model must be specifically designed to address the profound challenges of remoteness, workforce limitations, and the critical need for cultural safety, particularly for Aboriginal and Torres Strait Islander peoples.

A Safe and Accessible VAD Framework for the Northern Territory

The Centralised Service Model and the Primacy of Palliative Care

The 2024 Independent Expert Panel Report (the 2024 Report) correctly identifies the significant challenges a community-based VAD model would face in the Northern Territory, including workforce shortages in remote areas and the potential risk to clinicians in small communities. Consequently, its central recommendation for a single, centralised, stand-alone service for VAD delivery is one that the AMA NT endorses.

A centralised model offers numerous advantages that are critical in the Territory context. It provides a clear, single point of contact for patients, families, and referring practitioners, simplifying navigation of the system. It effectively manages the process for conscientious objection referrals, as the obligation on a non-participating practitioner is simply to refer to the central service, not to find an alternative individual practitioner. Most importantly, it allows for the development of a dedicated, highly skilled, multidisciplinary team with specific expertise in the legal, ethical, and clinical complexities of VAD, ensuring consistency and quality of care.

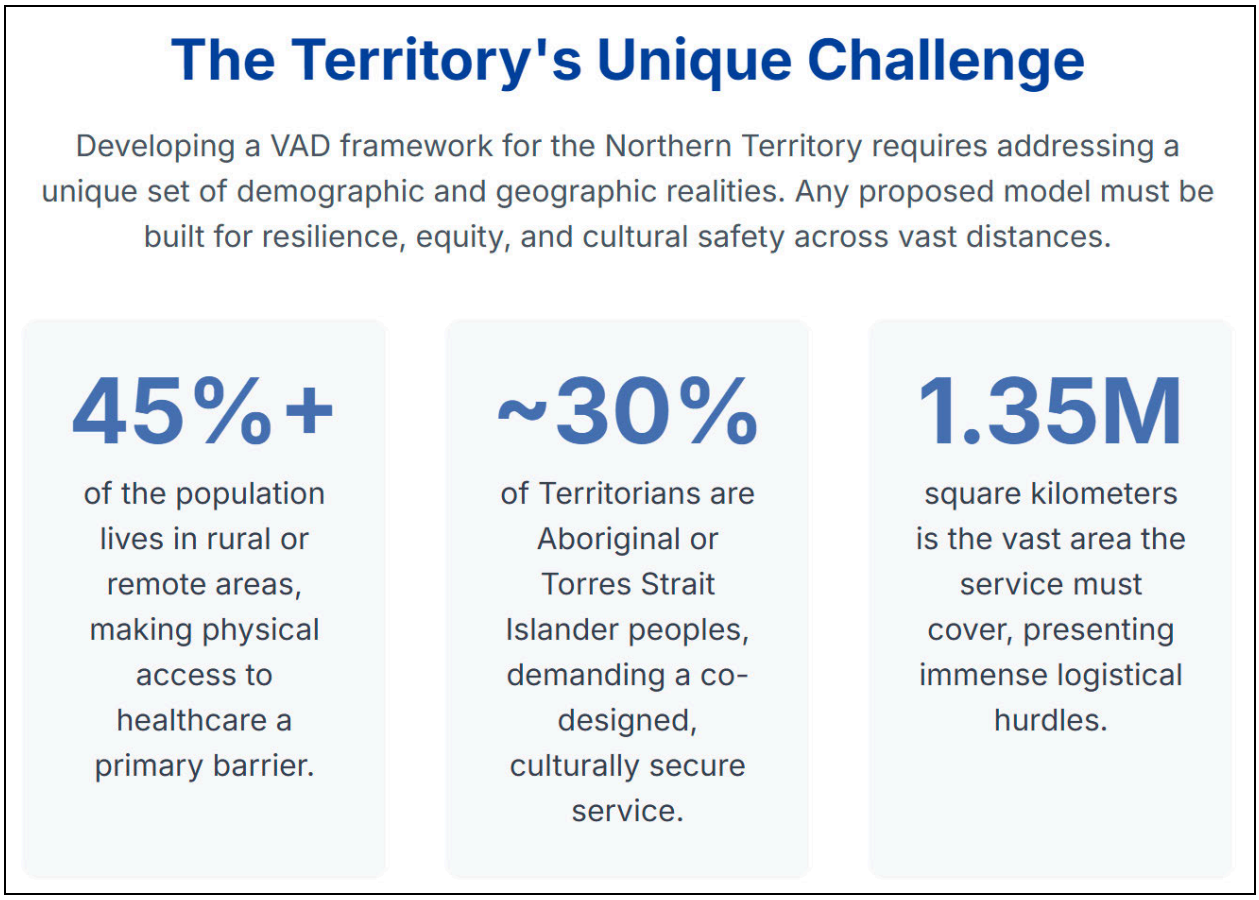
The recommendation that this service be physically separate from existing NT Health facilities, particularly palliative care services, is a crucial safeguard. This separation is vital to avoid any perception that VAD is a standard or expected component of palliative care. Such a perception could have a devastating impact on trust and service uptake, particularly among Aboriginal and Torres Strait Islander peoples, potentially deterring them from accessing essential and culturally vital end-of-life care.

During verbal testimony before this Committee, the AMA NT was asked to comment on the resource implications of VAD for palliative care services. The AMA's national position is unequivocal: investment in VAD must never compromise the appropriate provision and resourcing of palliative care. The introduction of VAD should not be viewed as a zero-sum resource competition. On the contrary, evidence and experience from other jurisdictions demonstrate that the public discourse and increased community awareness surrounding the introduction of VAD acts as a catalyst for greater engagement with *all* end-of-life options. As health literacy around dying and death improves, the demand for and uptake of palliative care services invariably increases.

Therefore, funding for a VAD service is not merely an additional cost to the health system; it is a trigger that necessitates a concurrent, and likely greater, new and protected investment in Territory Palliative Care services. This is essential to meet the induced demand and to uphold the fundamental ethical principle that VAD is a choice to be made from a full suite of high-quality options, not a default pursued due to the failure or inaccessibility of other services. The Committee's final report must recommend a separate, protected, and

significantly increased funding stream for palliative care, to be implemented in parallel with any VAD legislation. This is a prerequisite for an ethical VAD system in the Territory.

Ensuring Equitable Access for All Territorians



The Northern Territory's geography presents the single greatest challenge to delivering an equitable VAD service. With over 45% of the population living in rural and remote areas, any model that relies solely on in-person consultations in major centres will systematically fail a significant portion of the population. As stated in the AMA *Position Statement* and in verbal testimony, the use of telehealth is essential to providing safe and equitable access to VAD in the Territory.

However, a formidable barrier exists in the form of the Commonwealth *Criminal Code Act 1995*, which criminalises the use of a carriage service (such as telephone or video conferencing) to discuss or provide information related to suicide. A Federal Court decision has confirmed this prohibition extends to VAD services. A recent attempt to amend this legislation, the *Criminal Code Amendment (Telecommunications Offences for Suicide Related Material—Exception for Lawful Voluntary Assisted Dying) Bill 2024*, was introduced as a private member's bill but was removed from the Notice Paper in August 2024, indicating that a

federal legislative solution is not imminent.

This federal prohibition is not merely an inconvenience for the NT; it is a fundamental impediment to equitable access. It imposes immense financial, physical, and emotional burdens on the Territory's most vulnerable patients, forcing them to travel long distances while terminally ill to satisfy a requirement for multiple in-person consultations. This effectively creates a two-tiered system where access to a lawful medical service is determined by geography and wealth, a situation that directly contravenes the core principle of equitable access to healthcare.

While the NT Government must legislate to permit the use of telehealth for VAD, as recommended by the 2024 Report, it must also recognise the current legal reality. The NT Government must be urged to advocate forcefully at a national level for the amendment of the *Criminal Code Act 1995*. In the interim, a robust, fully-funded travel support scheme is not an optional extra but an essential stop-gap measure to mitigate this federally-imposed inequity. Jurisdictions like Western Australia and Queensland have implemented such schemes, providing a blueprint for the Territory.

Table 1: Comparative Analysis of Regional Access Support Schemes

Service	**Western Australia (Regional Access Support Scheme - RASS)**	**Queensland (QVAD-Access)**
Administration	Managed by the Statewide Care Navigator Service (SWCNS)	Managed by QVAD-Support, the statewide care coordination service
Funding Scope	Provides financial support for travel and accommodation	Covers the most clinically appropriate and cost-effective mode of transport
Eligible Persons	Patient, a support person/escort, practitioners, and interpreters.	Patient, a support person, authorised VAD practitioners, and interpreters
Covered Expenses	Flights, accommodation, vehicle hire, and other travel-related costs	Travel costs for journeys over 50 km one-way

Practitioner Support	Can fund practitioner travel to the patient. Compensates practitioners who support regional patients for their mandatory training time	Can fund practitioner travel to the patient if a local provider is unavailable. Does not cover consultation costs or travel for Queensland Health employees.

This comparison demonstrates that comprehensive, state-funded schemes are both feasible and necessary to bridge the access gap. A Northern Territory Regional Access Support Scheme, learning from these models, is an essential component of any VAD framework. The most straightforward solution would be to utilise an existing system, such as the NT Patient Assisted Travel Scheme

Practitioner and Process Safeguards

Practitioner Qualifications, Training and Scope

A central question for the Committee is the required level of qualification for medical practitioners assessing VAD eligibility. The 2024 Report pragmatically recommended against a rigid requirement for specialist expertise in the patient's specific condition, citing the NT's significant workforce shortages as a potential barrier to access. This contrasts with the initial model in Victoria, which required such expertise.

The AMA NT supports a nuanced, competency-based approach. The position of the Royal Australasian College of Physicians (RACP) is instructive, advocating that legislation should focus on defining the required "domains of expertise" and ensuring assessments are underpinned by "adequate physician-patient relationships, including appropriate training, skill and experience," rather than being restricted by particular qualification levels that could create access barriers.

The tension between ensuring expert oversight and maintaining equitable access in a resource-constrained environment like the NT is significant. A rigid requirement for a disease-specific specialist to conduct assessments is unworkable and would deny access to many eligible Territorians. Conversely, allowing any medical practitioner to make a complex prognostic decision without a clear support structure could risk patient safety. The optimal model resolves this tension not by lowering standards, but by redesigning the process.

The AMA NT proposes a model where assessing practitioners—for example, medical practitioners with general registration and at least five years of experience, or those with specialist registration for at least one year, consistent with the Queensland model and our verbal testimony—must have completed mandatory, accredited, NT-specific VAD training. Crucially, the legislation must then mandate a formal consultation pathway. As part of the first assessment, the coordinating practitioner must be legally required to obtain and document confirmation of the patient's diagnosis and prognosis from a relevant medical specialist. This provides the necessary expert oversight without becoming a physical gatekeeper to the process. This hybrid model balances the need for robust clinical governance with the practical realities of healthcare delivery in the Territory.

Regardless of the model chosen, this will increase the workload of our current specialist medical workforce. Whilst the numbers of patients expected to access VAD in the first year of operation is expected to be small and can be accommodated by the existing workforce, we will quickly reach a saturation point requiring dedicated investment in workforce expansion. The use of resources external to the VAD service must be captured and reviewed by the VAD oversight mechanisms to ensure we can accurately predict this saturation point and avoid it becoming a barrier to service provision.

Eligibility and Capacity

The 2024 Report's recommendation for a single 12-month prognosis timeframe for all eligible conditions is a sensible and compassionate approach that the AMA NT fully supports. As noted in verbal testimony, a shorter six-month timeframe may be insufficient for patients in remote areas to navigate the logistical and emotional steps of the VAD process, including travel for assessments and time with family. A uniform 12-month window, as adopted in Queensland, simplifies the eligibility criteria and provides a more realistic period for considered decision-making, aligning with the AMA's principle of reducing barriers for regional patients.

The Committee also sought the AMA NT's position on the requirement in the original *Rights of the Terminally Ill Act 1995* (ROTI Act) for a mandatory psychiatric assessment for all applicants. This requirement is an anachronism, reflecting a nascent understanding of VAD in 1995. Modern VAD frameworks, supported by expert bodies such as the Royal Australian and New Zealand College of Psychiatrists (RANZCP), correctly distinguish between a rational, capacitous decision to end intolerable suffering and a decision that is impaired by a treatable mental illness. The RANZCP position is clear: while psychiatrists have a key consultative role, an assessment of decision-making capacity is a core clinical skill and does not necessarily require a psychiatrist.

Mandating a psychiatric assessment for every patient pathologises the VAD process, creates a significant and unnecessary barrier to access, and misuses scarce psychiatric resources. The appropriate and modern safeguard, consistent with good medical practice in all other clinical domains, is for the assessing practitioners—who must be thoroughly trained in capacity assessment—to be required to refer for a specialist psychiatric or geriatric opinion if they have *any clinical doubt* about the patient's capacity or the presence of a treatable condition that is impairing their judgment. The AMA NT therefore strongly recommends against a mandatory psychiatric assessment requirement, advocating instead for comprehensive capacity assessment modules within the mandatory VAD training and clear referral pathways in the clinical guidelines.

Conscientious Objection

The AMA *Position Statement* strongly supports the right of all doctors to conscientiously object to participation in VAD. This is a fundamental ethical protection for medical professionals. However, this right is not absolute; it is balanced by the professional duty to the patient. A doctor who conscientiously objects must inform the patient of their objection in a timely manner and must not obstruct the patient's access to care. They have an obligation to ensure the patient has sufficient information to enable them to seek that care from another practitioner or service.

The proposed centralised VAD service model provides an elegant and practical solution to this ethical challenge. As articulated in the AMA NT's verbal testimony, the duty of a

non-participating practitioner becomes clear and manageable. They are not required to find an alternative, willing individual practitioner, which can be difficult and distressing. Instead, their sole obligation is to provide the patient with the contact information for the single, centralised VAD service. This act of providing information does not constitute participation in the act of VAD itself; it is an act of fulfilling their duty of care to the patient by ensuring they can access a lawful health service. This model respects the practitioner's conscience while simultaneously upholding the patient's right to access care, effectively resolving a major point of tension in other VAD implementation models.

A VAD Model Designed for the Northern Territory

Cultural Safety and Co-Design with Aboriginal and Torres Strait Islander Peoples

The 2024 Report and the Committee's Consultation Paper correctly identify that addressing the cultural safety of Aboriginal and Torres Strait Islander peoples is a core, non-negotiable requirement of any VAD framework in the NT. The AMA NT's verbal testimony further stressed the need for genuine co-design with Indigenous communities and the critical role of appropriately trained interpreters.

The concept of co-design must be understood as more than simple consultation. Best-practice frameworks for co-designing health services with Aboriginal and Torres Strait Islander peoples emphasise the need to move beyond tokenistic engagement towards genuine partnership. This involves sharing power, facilitating Indigenous leadership, building trusted relationships before developing solutions, and privileging Indigenous knowledge systems and ways of knowing, being, and doing.

There is a significant risk that "co-design" becomes a checkbox item to be addressed during the 18-month implementation phase after legislation is passed. This would be a profound mistake. Effective co-design, which builds the trust necessary for a culturally safe service, cannot be rushed and must precede operationalisation. It requires ceding decision-making power to Aboriginal and Torres Strait Islander partners to determine how the VAD service will respectfully interact with their communities, how complex concepts like "capacity" and "voluntariness" are communicated in a culturally resonant way, and how family, kinship, and community decision-making structures are respected within the VAD process.

The AMA NT recommends that the Committee's report call for the NT Government to fund and establish a formal, Indigenous-led co-design process. This process must be conducted in genuine partnership with key bodies such as the Aboriginal Medical Services Alliance Northern Territory (AMSANT). Its mandate should be to develop the culturally-specific protocols, communication strategies, interpreter training modules, and operational guidelines for the VAD service. This foundational work must be completed *before* the 18-month implementation period for the broader service begins, as it is essential for the legitimacy, safety, and cultural integrity of the entire system.

Proposed Operational Model for a Standalone NT VAD Service

The Proposed "Hub & Spoke" Model

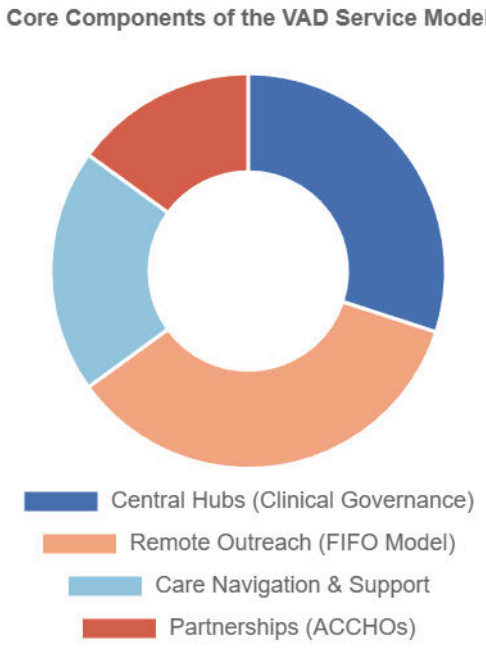
To ensure both quality control and equitable access, a centralised service with a strong outreach capability is recommended. This model separates VAD from palliative care to maintain trust and clarity.

Service Structure

🏙️ **2 Primary Hubs (Darwin & Alice Springs)**
Centralised administrative and clinical cores staffed by dedicated teams, including care navigators.

✈️ **Remote "Spokes"**
Fly-in, fly-out practitioners for in-person assessments in remote communities, fully funded by a travel scheme.

🤝 **Partnership with ACCHOs**
Close collaboration with Aboriginal Community Controlled Health Organisations to ensure culturally safe delivery.



In response to the Committee's request for a more tangible operational model, the AMA NT proposes a "Hub and Spoke" structure. This model integrates the recommendation for a centralised service with the practical realities of delivering outreach services across the Territory, drawing lessons from the regional access schemes in Western Australia and Queensland.

- **Hubs**: The model would be based around two primary service hubs, one in Darwin to serve the Top End and one in Alice Springs for Central Australia. These hubs would be the

administrative and clinical core of the service. They would be co-located with other health infrastructure for efficiency but must remain operationally and physically distinct from palliative care services like hospices to maintain the critical separation of services.

- **Staffing**: Each hub would be staffed by a small, permanent team comprising a clinical lead (a senior physician with experience in end-of-life care), VAD care navigators (experienced nurses or allied health professionals who would be the primary point of contact for patients), and administrative support. This core team would be supplemented by a pool of trained and credentialed VAD practitioners (coordinating and consulting practitioners) engaged on a sessional or on-call basis from the local medical community.
- **Patient Journey (Urban/Regional)**: For a patient in Darwin or Alice Springs, the process would be straightforward. A referral from their GP or a self-referral would be made to the local hub. A care navigator would be assigned and would manage the entire process, coordinating assessments with the VAD practitioners, which could take place at the hub's facility, the patient's home, or their residential aged care facility.
- **Spokes (Remote Access)**: The outreach component is the most critical element.
    - Initial Contact: A patient or their local clinician in a remote community would contact the nearest hub. The care navigator would manage the initial information exchange, strictly adhering to the legal constraints of the *Criminal Code Act 1995*.
    - Assessment: The service would utilise a fly-in, fly-out (FIFO) model for assessments. A trained VAD practitioner from the hub would travel to the patient's community to conduct the mandatory in-person assessment. This travel would be fully funded by a dedicated Northern Territory Regional Access Support Scheme (NT RASS).
    - Coordination: The VAD service would be required to work in close partnership with existing remote health services, particularly Aboriginal Community Controlled Health Organisations (ACCHOs), to ensure assessments are conducted in a culturally appropriate, safe, and logistically sound manner.
    - Administration: For practitioner administration, the administering practitioner would travel to the patient. For self-administration, the Statewide Pharmacy Service (based at the hubs) would coordinate the secure and timely delivery of the VAD substance, adopting the logistical solutions developed by the WA Statewide Pharmacy Service for managing supply to remote areas.

Governance, Oversight and Implementation

Independent Oversight

The AMA NT strongly endorses the 2024 Report's recommendation to establish an independent statutory VAD Review Board. This body is essential for monitoring compliance, collecting data, and ensuring the safe and transparent operation of the Act. As stated in verbal testimony, the composition of this board is critical. Its membership must include a senior physician (preferably with expertise in palliative care), legal and community representation, and, crucially, an Aboriginal health expert nominated in partnership with AMSANT to ensure cultural governance is embedded at the highest level.

The Review Board will be tasked with reviewing every case of VAD to monitor compliance and patient experience. Further monitoring should include quarterly system level reviews, to ensure the service is meeting key performance indicators. The Review Board should also provide public annual reports on the function of the VAD service, including total numbers seen and operational costs to ensure transparency.

Review Mechanisms

The provision for a right of review of certain VAD eligibility decisions - specifically residency, decision-making capacity, and voluntariness - to the Northern Territory Civil and Administrative Tribunal (NTCAT) is an important safeguard. The AMA NT supports this recommendation, with the critical caveat that the right to apply for such a review must be limited to the person seeking access to VAD. This provides an essential avenue for recourse for the patient without opening the process to potentially vexatious or distressing legal challenges from family members or other parties who may disagree with the patient's autonomous decision.

Implementation & Legislative Review

The 18-month implementation timeframe proposed in the 2024 Report is realistic and necessary. This period is required not only to establish the physical infrastructure and administrative processes of the service but, more importantly, to undertake the comprehensive practitioner training and the foundational co-design work with Aboriginal and Torres Strait Islander communities. The proposed legislative review timeline - an initial review after three years of operation, followed by five-yearly reviews - is also appropriate. This schedule will allow for sufficient data and operational experience to be accumulated to inform a meaningful and evidence-based evaluation of the legislation's effectiveness and safety.

Summary & Recommendations

The Australian Medical Association Northern Territory respectfully submits the following key recommendations for the Committee's consideration:

1. **Enact VAD Legislation**: That the Northern Territory enact VAD legislation based on the principle of equitable access, consistent with frameworks in other Australian jurisdictions and guided by the AMA *Position Statement on Voluntary Assisted Dying 2025*.
2. **Fund Palliative Care**: That any funding for a VAD service be accompanied by a separate, protected, and significantly increased funding stream for Territory Palliative Care services to meet the anticipated increase in demand for all end-of-life care options.
3. **Adopt a Centralised "Hub and Spoke" Model**: That the NT establish a single, centralised VAD service that is physically and administratively separate from palliative care, operating on a "Hub and Spoke" model with primary hubs in Darwin and Alice Springs and a well-resourced outreach capacity.
4. **Establish a Regional Access Support Scheme**: That a Northern Territory Regional Access Support Scheme (NT RASS) be established and fully funded to cover the costs of travel and accommodation for patients, support persons, and practitioners to overcome the barriers of distance.
5. **Advocate for Federal Telehealth Reform**: That the NT Government advocates forcefully at the national level for the amendment of the Commonwealth *Criminal Code Act 1995* to permit the use of telehealth for VAD services.
6. **Implement a Competency-Based Practitioner Model**: That practitioner eligibility be based on a combination of experience (e.g., 5+ years general registration or 1+ year specialist registration) and completion of mandatory NT-specific training, and that the assessment process legally requires the coordinating practitioner to obtain and document confirmation of diagnosis and prognosis from a relevant medical specialist.
7. **Reject Mandatory Psychiatric Assessment**: That the legislation does not include a requirement for mandatory psychiatric assessment, but instead mandates comprehensive training in capacity assessment for all VAD practitioners and requires referral for specialist opinion where any clinical doubt exists.
8. **Mandate Pre-Implementation Co-Design**: That the NT Government immediately funds and establishes a formal, Indigenous-led co-design process, in partnership with AMSANT and Land Councils, to develop the culturally-specific protocols and operational guidelines for the VAD service *before* the 18-month implementation period commences.
9. **Establish an Independent Review Board**: That an independent statutory Review Board be established to oversee the operation of the Act, with its membership to include a senior physician, legal and community representatives, and an Aboriginal health expert.