

ethical end of life care

Dear Senator,

I am writing on behalf of Ethical End of Life Care to ask you to oppose any move to allow consultations or lethal prescriptions for euthanasia or assisted suicide (“VAD”) to occur via telehealth.

I also write as an experienced respiratory physician, who has the great privilege of caring for patients with life-shortening illness from diagnosis until the end of their life.

With life-and-death issues involved, careful and sensitive assessments of capacity, coercion, elder abuse, family pressure and untreated depression are essential, and require careful, face-to-face clinical engagement. Telephone or video consultations make these risks much harder, if not impossible, for practitioners to identify, particularly where the practitioner does not know the person well.

An example of the concern that experienced clinicians have about telehealth used for vulnerable patients is in the news on the day I write this letter (see <https://www.abc.net.au/news/health/2026-08-31/telehealth-ozempic-wegovy-eating-disorder/107016932>). In that article, a spokesperson for the Australian Health Practitioner Regulation Agency (AHPRA) is reported as saying that AHPRA

“...expected all practitioners to undertake a comprehensive and holistic assessment of all patients to properly assess that any recommended or prescribed treatment was appropriate...This includes assessment of any increased potential for vulnerability before proceeding with treatments”.

AHPRA further stated that

"Practitioners should recognise that telehealth is not appropriate for all consultations as the lack of in-person interaction can limit the ability to provide safe and effective care".

In other words, AHPRA recognises that there are significant risks of error and distress when doctors try to use a telephone or screen to navigate complex or emotionally

challenging situations. In my experience, there is generally no more vulnerable time in a person's life than when they are facing a life-shortening illness.

Experienced clinicians know that it can be very challenging to assess a patient's decision-making capacity, even when this is done face to face. It is equally challenging to assess for possible coercion or mental illness. Elder abuse rates are known to be at least 15%. The use of telehealth only increases the risk of VAD assessments missing such critical factors.

Regardless of how it is characterized, VAD is a form of suicide. This current proposal seeks to override the provision of the Commonwealth Criminal Code (as contained in [Schedule 1](#) of the [Criminal Code Act 1995](#)) that makes it an offence to use a carriage service to publish or distribute material that counsels or incites committing or attempting to commit suicide. Encouraging suicide by VAD via telehealth runs contrary to the goals of the National Suicide Prevention Strategy.

Each signatory to this letter is an experienced health professional who can affirm from first-hand experience the importance of face-to-face contact with patients when crucial decisions are involved and the patient is distressed, unwell and potentially subject to a range of pressures and influences. We know that our view is shared by the vast majority of practitioners, as is borne out by a recent survey that found only 8% of general practitioners who responded favoured allowing VAD via telehealth.

Our concern is particularly acute for regional, rural and remote Australians, people with disability, and First Nations communities, including in the Northern Territory, where serious health and social inequities remain and services are often scarce.

I personally have experienced patients from areas with less access to health-care and other services bringing up the topic of VAD as a "cry for help". With careful listening and person-centred care, this later turned out to be a symptom of their extreme vulnerability and lack of access to care, and not something that they ultimately believed they wanted to do. If a doctor proceeded with VAD in this circumstance, without fully understanding that person's mental health, relationships and beliefs, this would not be a freely made choice, but rather a choice made under duress from the lack of support and genuine care.

Regional, rural and remote Australians deserve equitable healthcare, as do all Australians. However, the answer to inadequate services is not to make VAD accessible by telehealth. The high rates of suicide amongst rural and Indigenous populations are well known. These communities also experience substantially poorer access to health, mental health, social support and palliative care services. In such circumstances, genuine "choice" is often profoundly constrained by isolation, illness, poverty and a lack of practical alternatives. The solution is to provide regional, rural and remote communities with access to the services they deserve, not for governments to avoid

that responsibility by substituting VAD via telehealth. VAD is a state and territory legislated option, and those jurisdictions can and should support necessary in-person access to health care and other services, instead of seeking to exempt VAD from Commonwealth safeguards.

Please vote against this proposal and instead support fair access to palliative care, mental-health care and social services for all Australians.

Yours sincerely,

Dr Luke Garske

MBBS Hons PhD Respiratory Physician

Chair, Ethical End of Life Care

Supported by:

[Names and details of supporting clinicians]

Ethical End of Life Care Limited(ACN 692029155) is a not-for-profit company limited by guarantee. Our Board comprises a broad range of medical practitioners, academics and others who share our vision around Australia. 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.